

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Stanislaw NMN Calak			2a. DATE OF DEATH MONTH DAY YEAR Oct. 17, 1983			2b. HOUR 5:15 a. M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 7, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN FACILITY, GIVE STREET ADDRESS) Rockville Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY Farmer	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Gregory Calak			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			13e. STREET ADDRESS 5906 Holland Road 20851			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 085-05-9727		17. INFORMANT ADDRESS Alexander Sadowski same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Thrombosis & cerebral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Thrombosis</u> (c) <u>Arteriosclerotic vascular disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Angioplasty 2 m. - repeated CVA.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30'</u> <u>5 yrs</u> <u>10 yrs</u>	
19a. DATE OF OPERATION <u>4/1/83</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>2 m. - repeated CVA.</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>4/1/83</u> to <u>10/17/83</u> , that (I) (we) last saw the deceased alive on <u>10/10/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Stephen N. Jones</u>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>10/17/83</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen N. Jones			22e. ADDRESS 809 Viers Mill Rd. Rockville, Md. 20851						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/22/83		23c. NAME OF CEMETERY OR CREMATORY Stanislaw Cemetery		23d. LOCATION CITY OR TOWN COUNTY Pine Island New York		
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.					25. DATE RECEIVED BY REGISTRAR OCT 24 1983				
1331 Rockville Pike, Rockville, Md. 20852					REGISTRAR'S SIGNATURE <u>[Signature]</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of any event.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
BEERYL CUMMINGS CADWELL				10-21-83				5:15 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
FEMALE		CAK		2 5 87		96 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
PLAINFIELD N.J.		U.S.A.				MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Wheaton		UNIVERSITY NURSING HOME		school teacher		RETIRED			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD.		MONTGOMERY		SILVER SPRING		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13900 OVERTON LANE 20904	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
ALBION		KETH CUMMINGS		ADA HARRIET		STUDLEY		(SAME AS #13 ABOVE)	
NO		265-60-4964		ELT. RAYMOND B. CADWELL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		4140		DUE TO, OR AS A CONSEQUENCE OF	
				(b)		Longstanding arteriosclerotic heart disease		DUE TO, OR AS A CONSEQUENCE OF	
				(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10-20-83 to 10-21-83, that (I) saw the deceased alive on 10-20-83, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
Morrill C. Quinnam Jr.		MD		10-21-83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
MORRILL C. QUINNAM JR. MD		11120 NEW HAMPSHIRE AVE. SILVER SPRING							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial.		10/24/1983		GEO. WASHINGTON		ADELPHI P.G. MARYLAND			
23e. FUNERAL DIRECTOR		23f. DATE REC'D. BY REGISTRAR		23g. REGISTRAR'S SIGNATURE					
Takoma Funeral Home.		OCT 24 1983		John J. Connel					
254 Carroll St. N. W. D. C.									

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Company

NAME

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) SIDNEY RALEIGH CAMDEN, JR.			2a. DATE OF DEATH MONTH DAY YEAR October 16, 1983		2b. HOUR 2:45 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR September 17, 1938		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Banker	12b. KIND OF BUSINESS OR INDUSTRY Banking Ind.	
13a. STATE D. C.			13b. COUNTY Washington	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Sidney Raleigh Camden, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thelma C. Claytor		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 225 48 7935		17. INFORMANT ADDRESS Dr. Daniel Camden 2803 N Main St. S. Boston, Va 24592	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1739 Respiratory failure - AIDS - Opportunistic infections Sev. weeks DUE TO, OR AS A CONSEQUENCE OF (b) Kaposi's Sarcoma DUE TO, OR AS A CONSEQUENCE OF (c) Interstitial Pneumonitis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION (ENTER IN PART I IF POSSIBLE)
Renal failure/mental status deterioration/GI bleeds/ulcerations with herpetic

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from September 13, 1983 to October 16, 1983, that X (we) lost saw the deceased alive on October 16, 1983, and that in X (y) (our) opinion death occurred on the date and hour and from the causes stated above X (I) (we) (did) X (X) (not) view the body after death.			
22b. SIGNATURE Ellen Mellow MD.	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 10/16/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELLEN MELLOW, MD.		22e. ADDRESS 9000 Rockville Pike, Bethesda, Md. 20814	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE Oct 17 1983	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia
24. FUNERAL DIRECTOR NAME Ives-Pearson F. Homes, Arlington, Va. 22201		25. DATE REC'D. BY REGISTRAR OCT 20 1983	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Theresa CAMPBELL			2a. DATE OF DEATH MONTH DAY YEAR 10 - 13 - 83			2b. HOUR 11:20 AM					
3 SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR July 7, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 68					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont Co MD.					
10. CITY OR TOWN OF DEATH Takoma PK.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sligo Garden Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Medicine Technician		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Washington, D.C.		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 522 21st Street, N.E.		
14. FATHER'S NAME FIRST MIDDLE LAST Peter Dominick Harrison				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Ford							

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 578 28 4705		17. INFORMANT ADDRESS Evelyn Thomas-sister-522 21st St., NE	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART 1: DEATH WAS CAUSED BY: 1629		IMMEDIATE CAUSE (a) Respiratory failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of the lungs			
		DUE TO, OR AS A CONSEQUENCE OF (c) Cs. metastatic to the brain			

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21; (1) OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (i) (this hospital) attended the deceased from July 18 1983 to 10/13/83 19 that (i) (we) last saw the deceased alive on 10/10/83 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (ii) we (did) (did not) view the body after death.							
22b. SIGNATURE Michael A. Roderiquez				DEGREE MD		22c. DATE SIGNED 10/18/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael A. Roderiquez				22e. ADDRESS 831 University Blvd., Silver Spring, MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 17, 1983		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME Stewart Funeral Home-4001 Benning Road, NE				25a. DATE REC'D. BY REGISTRAR OCT 21 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	



1. The first of these is the fact that the
2. second of these is the fact that the
3. third of these is the fact that the
4. fourth of these is the fact that the
5. fifth of these is the fact that the
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8. eighth of these is the fact that the
9. ninth of these is the fact that the
10. tenth of these is the fact that the

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR
William		F.		Canada	10/5/83							955 PM M
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS	
M. Male	White		5 MONTH 18 DAY 07 YEAR		76 YRS				MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Washington DC	USA				Montgomery MD.							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park	Washington Adventist Hospital				Baker				Safeway			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
13a. STATE 13b. COUNTY				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3537 Terrace Drive						
Maryland PG				Suitland								
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST				FIRST MIDDLE LAST								
Beverly Canada				Hattie Speedburg								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS		
No				577-05-5792		Hallie P. Canada				Same as #13		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

11629 IMMEDIATE CAUSE (a) respiratory failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) pneumonia
(c) DUE TO, OR AS A CONSEQUENCE OF
myocardial infarction

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a

employment, maternal history

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 10/1 to 10/5 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (2) (a) (did) did not view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Lewis H. Dennis, M.D.				M.D.		10/6/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Lewis H. Dennis, M.D.				831 University Blvd. E. Silver Spr, MD			

23a. BURIAL, CREMATION, REMOVAL (EXCEPT)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	10-8-83	Cedar Hill Cemetery	Suitland PG Md

24. FUNERAL DIRECTOR	25. DATE RECEIVED BY REGISTRAR	26. REGISTRAR'S SIGNATURE
Robert E. Wilhelm Funeral Home	Suitland, Md. OCT 13 1983	John J. Gabel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOANNE P. CAPOTOSTO			2a. DATE OF DEATH MONTH DAY YEAR 10-6-83			2b. HOUR 1:45 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 16, 1963		6. AGE (IN YEARS LAST BIRTHDAY) 20 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY College	
13a. STATE Maryland		13b. COUNTY P.G. Co.		13c. CITY OR TOWN Greenbelt		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 16D Crescent Road 20770	
14. FATHER'S NAME FIRST MIDDLE LAST Hugo - Capotosto				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred - Krahling					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No None				16b. SOCIAL SECURITY NO. 212-84-6150		17. INFORMANT ADDRESS Hugo Capotosto (Father) Same as # 13.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

2019 IMMEDIATE CAUSE (a) **Adult Respiratory Distress Syndrome**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 1/2 WEEKS

7 Months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from MARCH, 19 83 to OCT 6, 19 83 , that (I) (we) lost saw the deceased alive on OCT 5, 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Harvey J Katzen		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/6/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARVEY KATZEN				22e. ADDRESS 6525 Belcrest Road Hyattsville, Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct/10/83		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem. Cheltenham, P.G.Co., Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE	
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24. FUNERAL DIRECTOR NAME ADDRESS DATE REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE

Chambers Funeral Home Riverdale, Maryland

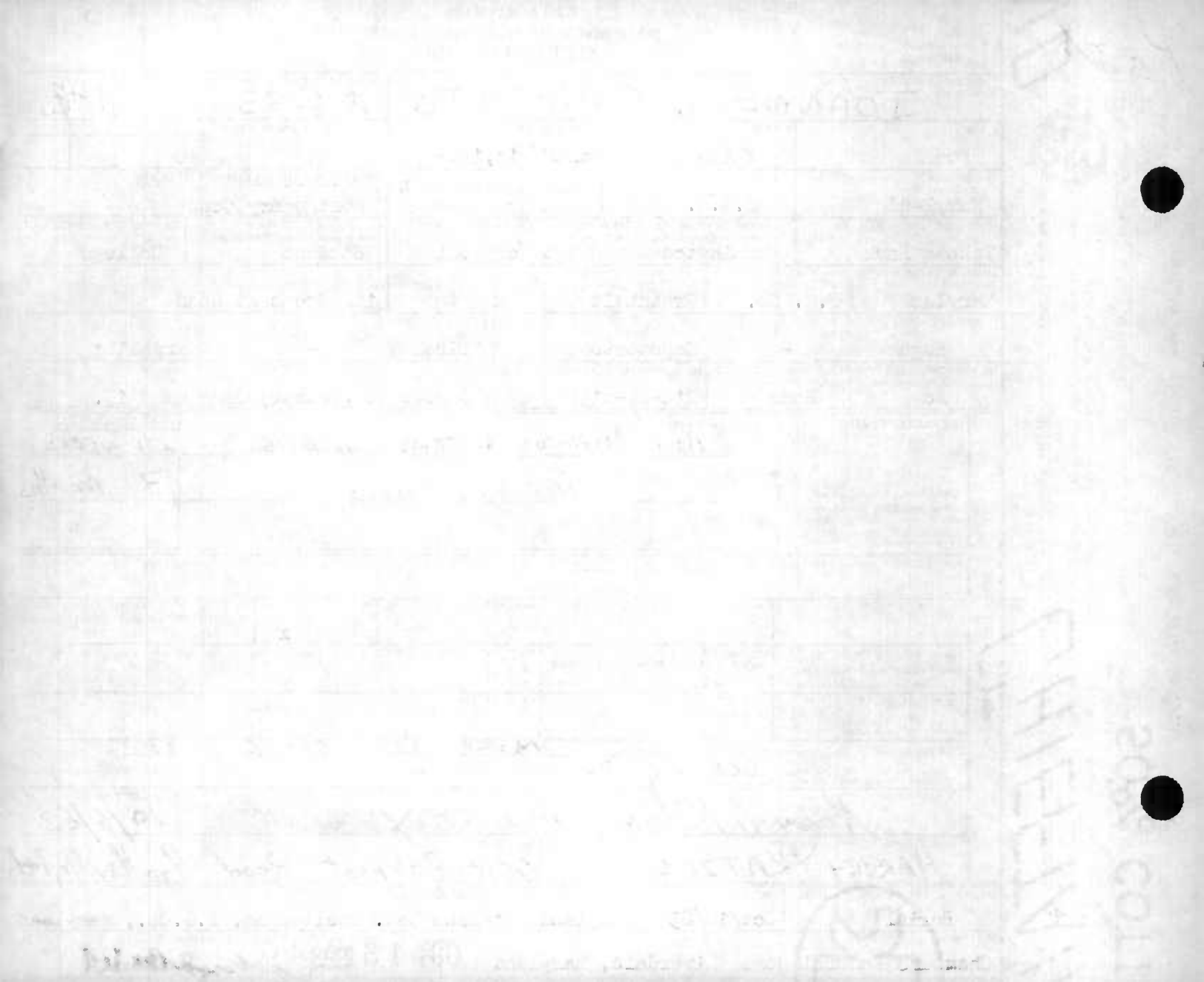
OCT 13 1983

James J. Connel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

27617

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR a.m.	
HILAND SMITH CARTER								10 06 19 83								10:08 a.m.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	White	Nov. 22, 1927		55 YRS.						October 6 1983						10:08 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Pennsylvania		U.S.A.						Montgomery									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEARS)		12b. KIND OF BUSINESS											
Silver Spring		Holy Cross Hospital		Systems Analyst		Defense Comm. Agency											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		110 E. Indian Spring Drive									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Edgar J. Carter		Bertha Becker															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		WW II		173-20-3980		Joan L. Carter (wife) Same as 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) <u>Chronic Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>None</u>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>John S. Rogers</u> M.D.		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED <u>Oct. 6/1983</u>											
EXAMINER'S NAME (TYPE OR PRINT)		John S. Rogers, M.D.		ADDRESS		1919 Seminary Road, Silver Spring MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION COUNTY STATE											
Removal		Oct. 6, 1983		Uniformed Services University of the Health Sciences		Bethesda, Maryland											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Capitol Funeral Service, Falls Church, VA				OCT 10 1983		John J. Carver											

Charles W. ...
...

Wm. ...
Wm. ...

John B. ...
...

Wm. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) EDWARD. LAWRENCE CAREY				2a. DATE OF DEATH MONTH DAY YEAR October 15, 1983			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 18, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County	
10. CITY OR TOWN OF DEATH Rockville,		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11108 Ardwick Drive,		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lawyer / Judge		12b. KIND OF INDUSTRY Administrative	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville,		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward F. Carey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne Bradley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 195 09 2008		17. INFORMANT ADDRESS Jane C. Carey (wife) see # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST 4/148 DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY THROMBOSIS							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 1 yr. 1 yr.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a Diabetes Mellitus, PULP ASD, CHF, U.T. I							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/3/1972 to 10/15/83 , that (I) (we) last saw the deceased alive on 10/15/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Stephen N. Jones, Md.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/15/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen N. Jones, Md.				22e. ADDRESS 809 Viers Mill Rd., Rockville, Md. 20851			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 18,		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery Silver Spring, Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey		ADDRESS P.A. Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR OCT 19 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

Blank lined paper with two binder holes on the right side. Faint, illegible handwriting is visible across the page, possibly representing a list or ledger. The text is mirrored and difficult to decipher.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) BERNARD E. CARROLL				2a. DATE OF DEATH MONTH 10 DAY 13 YEAR 83		2b. HOUR 12⁰² M	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH May DAY 12 YEAR 1919		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Policeman		12b. KIND OF BUSINESS OR INDUSTRY City Government	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST George MIDDLE D. LAST Carroll		15. MOTHER'S MAIDEN NAME FIRST Julie MIDDLE Marie LAST Lix		13e. STREET ADDRESS 7018 Exfair Road (20814)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II 577-03-0384		17. INFORMANT ADDRESS Ida M. Carroll, same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 4360 DUE TO, OR AS A CONSEQUENCE OF (b) ASPIRATION PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) CVA							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) CANCER - LUNG							
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 8/30/83 , 19 83 , to 10/13/83 , 19 83 , that if (we) last saw the deceased alive on 10/13/83 , 19 83 , and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If well did) did not view the body after death.							
22b. SIGNATURE Robert R. Goldstein DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/14/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EMOT R GOLDSTEIN				22e. ADDRESS 9410 OLD GEORGETOWN			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE October 17, 1983		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey		ADDRESS Bethesda, Maryland 20814		25a. DATE REC'D. BY REGISTRAR OCT 19 1983		25b. REGISTRAR'S SIGNATURE John J. Gair	

BP

10/10/2013

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MELVA M. CATLETT			2a. DATE OF DEATH MONTH DAY YEAR OCT 26, 1983		2b. HOUR 6:02 A	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 19, 1892		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH SILVER SPRING			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holt Cross Hospital			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY own home			
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville	
14. FATHER'S NAME FIRST MIDDLE LAST John W. Kline			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tenna Reigner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) N/A		17. INFORMANT ADDRESS Lowell T. Catlett-gr-son-(same as 13e)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO-SCLEROTIC HEART DISEASE YEARS DUE TO, OR AS A CONSEQUENCE OF (c) WIDESPREAD ARTERIO-SCLEROSIS YEARS						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CEREBRAL ARTERY DISEASE, HYPERTENSION, ARTHRITIS						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4-7 19 81 , to 10/26 19 83 , that (I) (we) last saw the deceased alive on 9/29 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE R. Delaney MD		DEGREE MD		22c. DATE SIGNED 10/29/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD P. DELANEY MD		22e. ADDRESS 4323 HARVARD ST SK SPR MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-29-83		23c. NAME OF CEMETERY OR CREMATORY Greenway Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Berkeley Morgan W. Virginia		25a. DATE REC'D. BY REGISTRAR OCT 27 1983				
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE John J. Conner				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ANNIE T CHILDS			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 3, 1983			2b. HOUR 12³⁰ P.M.	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JANUARY 27, 1897	6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN WHEATON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 11603 GRANDVIEW AVE. 20902			
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE F. ADAMS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY DEMENT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-12-6633		17. INFORMANT SON-IN-LAW ADDRESS CHARLES R. BAKER SAME AS 13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4409
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Generalized Arteriosclerosis**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

10 minutes**Several years**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1963 to 10-3-83 , that (I) (we) last saw the deceased alive on 10-3-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Morris Perry	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10-3-83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Morris Perry		22e. ADDRESS 11602 Georgia Ave, Silver Spring Md. 20902	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE OCT. 6, 1983	23c. NAME OF CEMETERY OR CREMATORY NATIONAL MEMORIAL PARK FALLS CHURCH	23d. LOCATION CITY OR TOWN COUNTY STATE VIRGINIA
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		25a. DATE REC'D. BY REGISTRAR OCT 13 1983	
25b. REGISTRAR'S SIGNATURE John J. Smith		25c. REGISTRAR'S SIGNATURE	
500 UNIVERSITY BLVD., W. SILVER SPRING, MD.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 should be filed within 72 hours after death. The medical examiner must be notified at once.

MEDICAL CERTIFICATION

AMERICAN T. CHILD 20142 OCTOBER 2 1951

YOUNG, MRS. E. (MRS. J. W.)

1000 1/2 S. 1st St. N. Minneapolis, Minn.

Dear Mrs. Young:

I am very glad to hear from you and hope you are well.

I am writing you to let you know that I have

just received your letter of the 10th.

I am sorry that I cannot give you the money you need



20% COB/03



Very truly yours,

1000

1000 1/2 S. 1st St. N. Minneapolis, Minn.

AMERICAN T. CHILD 20142 OCTOBER 2 1951

*Sudden collapse and death in
sunny lounge for no apparent reason*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) STEWART CLAPP				2a. DATE OF DEATH MONTH 10 DAY 12 YEAR 83 2b. HOUR 8 45 AM			
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH MONTH May DAY 2 YEAR 1911		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) terr. of New Mexico		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physician		12b. KIND OF BUSINESS OR INDUSTRY Medicine	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13e. STREET ADDRESS 4315 Ambler Drive 20895	
14. FATHER'S NAME FIRST Earle MIDDLE Hart LAST Clapp				15. MOTHER'S MAIDEN NAME FIRST Helen MIDDLE E. LAST Roberts			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII 473 14 8743		17. INFORMANT ADDRESS John L. Clapp Son Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory cessation 44104 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic illness (c) Wegener's granulomatosis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate several years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION not related				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. none 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) none		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 9/29 , 19 83 , that (I) (we) last saw the deceased alive on 9/29 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Allen J. O'Neill MD				DEGREE MD		22c. DATE SIGNED 10/12/1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allen J O'Neill MD				22e. ADDRESS 8601 Old Georgetown Rd, Bethesda			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Oct. 13, 1983		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria Virginia		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR OCT 13 1983			
				25b. REGISTRAR'S SIGNATURE John J. Conner			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <u>Helen V. Clark</u>					2a. DATE OF DEATH MONTH <u>10</u> DAY <u>15</u> YEAR <u>83</u> 2b. HOUR <u>2:23 P</u>				
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>July</u> DAY <u>31</u> YEAR <u>1900</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>83</u> YRS.		7. IF UNDER 1 YEAR MONTHS <u>2</u> DAYS <u>14</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery Co.,</u> MD.			
10. CITY OR TOWN OF DEATH <u>Rockville</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Shady Grove Adventist Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <u>Maryland</u> 13b COUNTY <u>Carroll</u> 13c CITY OR TOWN <u>Mt. Airy</u>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>202 Maple Ave. (21771)</u>		
14. FATHER'S NAME FIRST <u>Lucian</u> MIDDLE <u>O.</u> LAST <u>Runkles</u>					15. MOTHER'S MAIDEN NAME FIRST <u>Laura</u> MIDDLE <u>Virginia</u> LAST <u>Harrison</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>					16b. SOCIAL SECURITY NO. <u>213-74-3592</u>		17. INFORMANT ADDRESS <u>Frederick, Md.</u> <u>Robert E. Clark, 5902 Quinn Rd.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <u>1539</u> IMMEDIATE CAUSE (a) <u>SEPTIC SHOCK</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS.</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>PERFORATION OF COLON</u>								<u>48 hrs.</u>	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARCINOMA OF RIGHT COLON</u>								<u>UNKNOWN</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>RENAL FAILURE</u>									
19a. DATE OF OPERATION <u>10/14/83</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>PERITONITIS</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>OCT 14</u> , 19 <u>83</u> , to <u>OCT 15</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>OCT 15</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Ernest D. Hanowell</u>					DEGREE <u>MD.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10/15/83</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ERNEST D. HANOWELL</u>					22e. ADDRESS <u>10401 OLD GEORGETOWN RD BETHESDA</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>10-18-1983</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Prospect</u>			23d. LOCATION CITY OR TOWN COUNTY STATE <u>Frederick, Md.</u>		
24. FUNERAL DIRECTOR NAME <u>Charles W. Burrier, Jr., Sykesville, Md.</u>					25a. DATE REC'D. BY REGISTRAR <u>OCT 19 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>		

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Annette M. Clay			2a. DATE OF DEATH MONTH DAY YEAR October 6, 1983			2b. HOUR 5:20 P.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 2, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Retirement Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Social Worker		12b. KIND OF BUSINESS OR INDUSTRY Crittenden Home	
13a. STATE Md. 20815		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George G. Morse		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie ** Swett		13e. STREET ADDRESS 8700 Jones Mill Road		20815	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- 156-26-8450A		17. INFORMANT ADDRESS Robert H. Shuman, 5221 W56th St., Edina, Minn.			

18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cardiovascular atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate Unknown	
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Carcinoma of left breast (modified radical mastectomy 6/17/83)			
19a. DATE OF OPERATION 6/17/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Sx for cancer	
20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. INJURY OCCURRED: WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION STREET CITY OR TOWN COUNTY STATE		21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
22a. I certify that (I) (this hospital) attended the deceased from [December 21, 1979] to [October 6, 1983], that (I) last saw the deceased alive on [September 1, 1983], and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE George H. Gawler, MD		DEGREE	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) George H. Gawler, MD		22d. ADDRESS 6917 Belington Road, Bethesda, MD 20814	
22e. DATE SIGNED 10/6/83		22f. SIGNATURE John J. Gawler	

23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) Cremation		23b. DATE Oct. 10, 1983		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.				25. DATE RECD. BY REGISTRAR OCT 13 1983			
5130 Wisconsin Ave., NW, Washington, D.C. 20016				John J. Gawler			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/interment permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
MARY			K	CLEMENTS	10-10-83					8:30 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		December 16, 1890		92		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Meriden, Conn.		United States				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park		Washington Adventist Hospital				Housewife		at home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Pr. George		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1801-Greenwich Woods Drive 20903			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Michael - Kiniry				FIRST MIDDLE LAST Ellen - Fitzgerald							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				578-62-3269		Catherine M. Brewer (Daughter) Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive heart failure</u> <u>4241</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis, Aortic stenosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>probable Pulmonary embolism</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10/5/83</u> to <u>10/10/83</u> , that (I) (we) last saw the deceased alive on <u>10/10/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
Tony P. Kannarakat						MD		10/10/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
Tony P. KANNARAKAT						8001 16th St Silver Spg. MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			10-13-1983		Cedar Hill Mausoleum		Suitland, Pr. George, Maryland				
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
J. Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002						19 1983		John J. Conner			

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December 1971

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Abstract

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Abstract

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U. S. 1st Regt. '03-1880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH 10	DAY 3	YEAR 83	2b. HOUR 9:50 AM
1. DECEASED NAME (TYPE OR PRINT)		FIRST AMY	MIDDLE LEE	LAST CLINE			
1. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR March 26, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Suburban Bank		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James Daniel West		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Montgomery Phipps		13e. STREET ADDRESS 6905 22nd Place		20783	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 16 7976		17. INFORMANT 6905 22nd Place Russell Carter Hyattsville, Md. 20783			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Stroke DUE TO, OR AS A CONSEQUENCE OF (c) oat cell Lung Cancer							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk 1 wk 6 mo
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 16 Brain Metastases							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 10/3/83, to 10/3/83, that (1) (we) last saw the deceased alive on 10/3/83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Peter B. Sherer		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/3/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter B. Sherer		MD		22e. ADDRESS 3947 Ferrara Dr. Wheaton MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/6/83		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	
24. FUNERAL DIRECTOR NAME Frank's Sons Funeral Home, P.A. Hyattsville, Maryland				25a. DATE REC'D. BY REGISTRAR OCT 6 1983		25b. REGISTRAR'S SIGNATURE J. E. C. [Signature]	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIE E. COCHRAN			2a. DATE OF DEATH MONTH DAY YEAR OCT. 11, 1983		2b. HOUR 8:50 a.m.
3. SEX FEMALE	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR FEB. 1, 1906	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENN	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9524 COLESVILLE RD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKKEEPER		12b. KIND OF BUSINESS OR INDUSTRY TORO NAT'L CAPITAL
13a. STATE MARYLAND	13b. COUNTY MONT.	13c. CITY OR TOWN SIL. SPG.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN J. MCCORMICK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY McDEVITT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 184-22-3230		17. INFORMANT ADDRESS PHYLLIS COCHRAN DAUGHTER BETH. MD. 20814	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4140

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic Heart Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 month

10 years.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Renal Disease, undetermined etiology, with uremia; malignant Tumor of legs
Diabetes mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>October 6, 1983</u> to <u>October 11, 1983</u> , that (I) (we) lost saw the deceased alive on <u>October 6, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>John F. Gustafson</i>	DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10-11-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John F. Gustafson, M.D.	22e. ADDRESS 5480 Wisconsin Avenue, Chevy Chase, Md. 20815		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE OCT. 13, 1983	23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN	23d. LOCATION CITY OR TOWN COUNTY STATE SIL. SPG. MONT. MD.
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS	ADDRESS 500 UNIV. BLVD. W. SIL. SPG. MD. 20901	25a. DATE REC'D. BY REGISTRAR OCT 14 1983	
		REGISTRAR'S SIGNATURE <i>John J. Connel</i>	

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DATE _____

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1 - STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Gertrude					2a. DATE OF DEATH MONTH DAY YEAR Oct. 16, 1983				
3. SEX Female					2b. HOUR 1:30 PM				
4. RACE White					5. DATE OF BIRTH MONTH DAY YEAR July 21 1892				
6. AGE (IN YEARS LAST BIRTHDAY) 91					7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland					7b. CITIZEN OF WHAT COUNTRY? U.S.A.				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Potomac					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11401 Grundy Ct.				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security Analyst					12b. KIND OF BUSINESS OR INDUSTRY Banking				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland					13c. CITY OR TOWN Montgomery				
14. FATHER'S NAME FIRST MIDDLE LAST UNK					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 078-10-5443				
17. INFORMANT 11401 Grundy Ct. Mrs. Cecil Jurmain Potomac, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> 3109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Chronic heart syndrome, Sinus br., Malnutrition</u>									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22. I certify that (I) (this hospital) attended the deceased from <u>10/25</u> 19 <u>83</u> to <u>10 Oct</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>10/15</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
23a. SIGNATURE <u>Horace W. Bernton</u>					23b. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
23c. DATE SIGNED 10/17/83									
23d. PHYSICIAN'S NAME (TYPE OR PRINT) Horace W. Bernton, M.D.					23e. ADDRESS 4743 Bradley Blvd. Chevy Chase, Maryland				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation					23b. DATE Oct. 17, 1983				
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory					23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Md.				
24. FUNERAL DIRECTOR NAME WW Chambers Co. 8655 Ga. Ave. Silver Spring, Md.					25a. DATE REC'D. BY REGISTRAR OCT 19 1983				
25b. REGISTRAR'S SIGNATURE <u>John J. [Signature]</u>									



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER MUST EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND - 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

27629

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Emory Leeland XXMOTHER		2a. DATE KNOWN OF DEATH ESTIMATED 10-21-83 19		2b. HOUR 7:45P M	
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YRS 9 21 1970	6. AGE (IN YEARS LAST BIRTHDAY) 13 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 10-21-83 19
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) student		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. CITY Montgomery	13c. CITY OR TOWN Poolesville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 15510 Hughes Road 20837	
14. FATHER'S NAME FIRST MIDDLE LAST Emory L. Comer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frieda Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-82-1550		17. INFORMANT Emory Comer ADDRESS 15510 Hughes Rd Poolesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Multiple injuries 8136 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b). (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MIN. P.M. DAY MONTH YEAR 4 PM 10-21-83 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) bicyclist struck by a pick-up truck	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE River Rd & Hughes Rd. Poolesville, Md.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE Margarita A. Korell, M.D.		TITLE (SPECIFY) M.D. Assistant		DATE SIGNED 10-23-83	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 10/26/1983		23c. NAME OF CEMETERY OR CREMATORY Monocacy	
23d. LOCATION CITY OR TOWN COUNTY STATE Beallsville Montg. Md.		23e. DATE REC'D. BY REGISTRAR OCT 28 1983			
24. FUNERAL DIRECTOR NAME W.C. HILTON		25. REGISTRAR'S SIGNATURE BARNESVILLE, Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALICE Elizabeth CONVERSE					2a. DATE OF DEATH MONTH DAY YEAR 10 13 / 83			2b. HOUR 6:25 PM	
3. SEX Female		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 11 6 88		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 94 YRS.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhode Island		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CTY. MD			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BEL PRE HEALTH CARE CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5409 Amberwood Lane 20853	
14. FATHER'S NAME FIRST MIDDLE LAST John J. Pune				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Kelly					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 036-32-8424		17. INFORMANT ADDRESS Son John N. Converse, Jr. Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE 4140 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) ADVANCED GENERALIZED ARTERIOCLEROSIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 YRS 25 YRS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) HYPERTENSION									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from APRIL 19 72 , to OCT 3 19 83 , that (I) (we) last saw the deceased alive on SEPT 29 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John G. Nasou, MD						DEGREE		22c. DATE SIGNED 10-3-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN G. NASOU, MD.						22e. ADDRESS 800 GERTHING DR. SILVER SPRING, MD. 20910			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 7, 1983		23c. NAME OF CEMETERY OR CREMATORY Mt. St. Mary's		23d. LOCATION CITY OR TOWN COUNTY STATE Pawtucket Providence R. I.		
24. FUNERAL DIRECTOR NAME Francis J. Collins						25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE 001 6 1983 [Signature]			
500 University Blvd., W. Silver Spring, Md.									

BP

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Handwritten notes in the middle section, including the word "F" and some illegible cursive text.

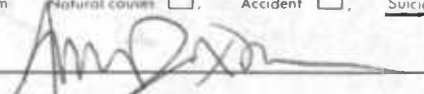

Handwritten notes at the bottom of the page, including the word "F" and some illegible cursive text.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 27631	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PAUL Andre COOK							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 19 83		2b. HOUR M 2:06 P.M.		
3 SEX Male	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR Apr. 2, 1962	6 AGE (IN YEARS) LAST BIRTHDAY YRS. 21	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 19 83	7d. HOUR M 2:06 P.M.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Press Helper		12b. KIND OF BUSINESS OR INDUSTRY Newspaper				
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6720 Wayne Wright Ave. 20851			
14. FATHER'S NAME FIRST MIDDLE LAST Paul Cook				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Ann Burton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none		17. INFORMANT ADDRESS Cheverly		Paul Cook 6337 Landover Rd. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perforating gunshot wound of chest (rifle)</u> 9552 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Body Only			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 10-19-19 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Self-inflicted.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5720 Wayne Wright Ave., Rockville, Mont., Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 10-20-83			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Oct. 25, 83		23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Landover P.G. Maryland			
24. FUNERAL DIRECTOR NAME Hunt Funeral Home				ADDRESS 2801 7th St. N.E. D.C.				25a. DATE REC'D. BY REGISTRAR OCT 31 1983			
								25b. REGISTRAR'S SIGNATURE 			

STATE OF NEW YORK
COUNTY OF ALBANY
IN SENATE,
January 12, 1904.

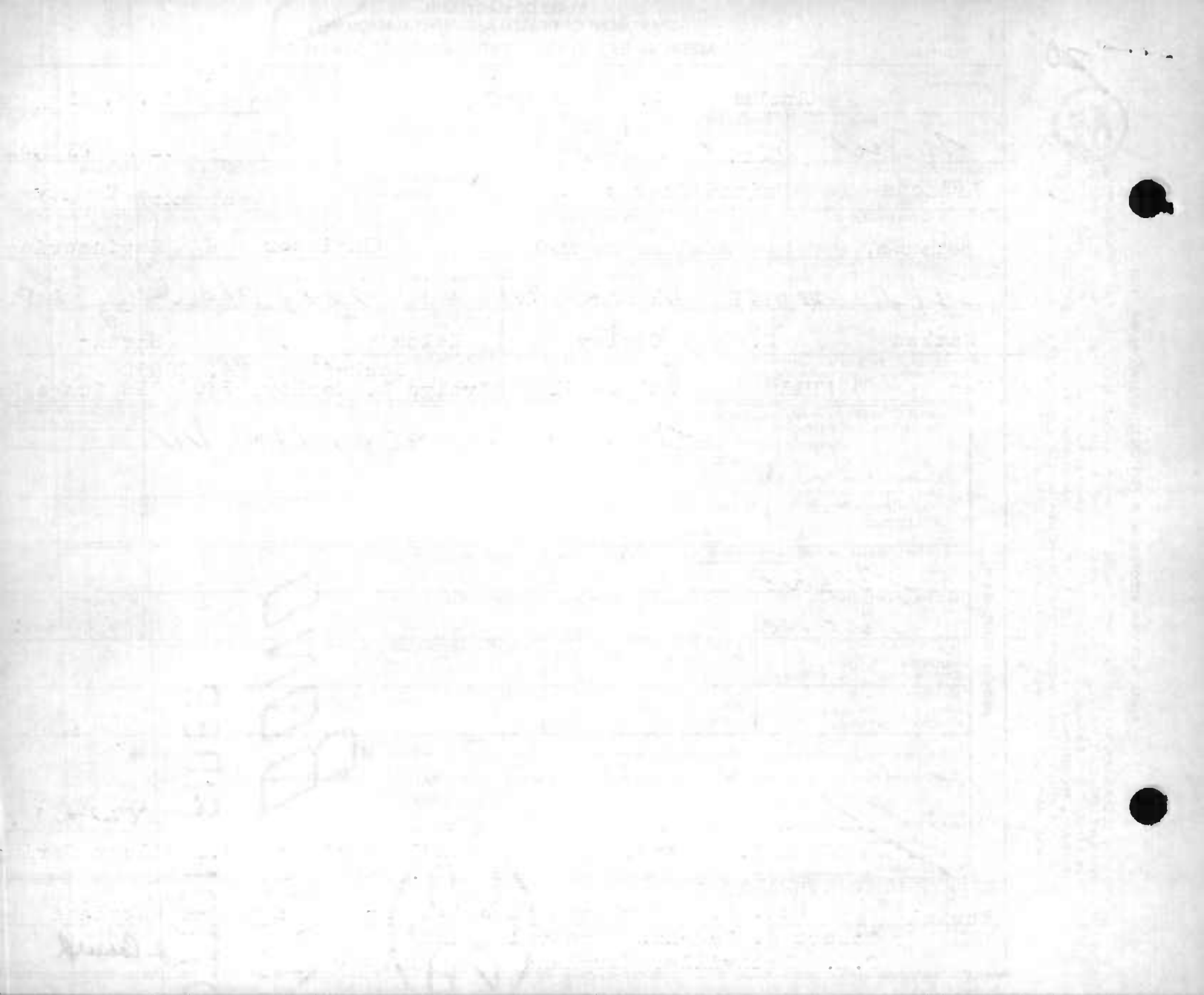
DAVID W. WILSON

ALBANY, N. Y.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PW 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 DAYS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

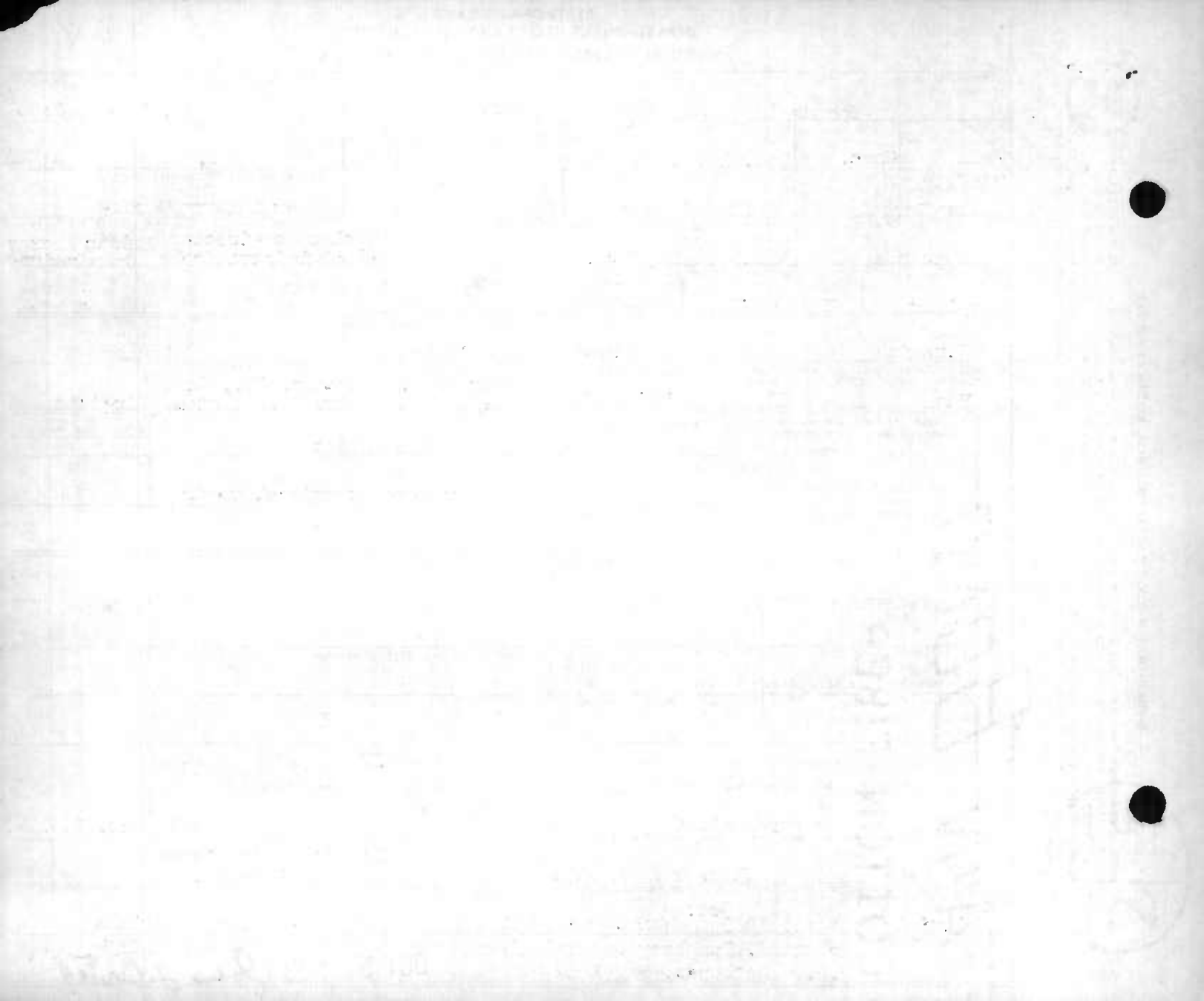
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										27032	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Charles E. Corley						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 10.24. 83		2b. HOUR 2:42A			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Mar. 16, 1925		6. AGE (IN YEARS) (LAST BIRTHDAY) 58 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 10.24. 19 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arizona				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				10. CITY OR TOWN OF DEATH Bethesda,				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer				12b. KIND OF BUSINESS OR INDUSTRY Engineering				13a. STATE MD.			
13b. COUNTY Mont.				13c. CITY OR TOWN Rockville				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS 7208 Old Stage Rd				14. FATHER'S NAME FIRST MIDDLE LAST Nathan N. Corley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen E. Haring			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW11 527 10 6198				17. INFORMANT Evalyn L. Corley, 7208 Old Stage Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers, MD				TITLE (SPECIFY) Dep. M.D. MEDICAL EXAMINER				DATE SIGNED 10.24/1983			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, MD				ADDRESS 1919 Seminary Rd., Silver Spring Md. 20910							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Oct. 27,				23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park			
23d. LOCATION CITY OR TOWN Rockville, Maryland				23e. DATE REC'D. BY REGISTRAR OCT 25 1983				23f. REGISTRAR'S SIGNATURE John J. Corley			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home's				ADDRESS P.A. Rockville, Maryland							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										2. 7 6 3 3		
1- STATE REGISTRAR										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) Thomas Aloysius Courtney						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR Oct. 2 19 83		2b. HOUR 2:00				
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR Dec. 15, 1901		6. AGE (IN YEARS) LAST BIRTHDAY 81 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD Oct. 2, 19 83		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5113 Viking Road						12a. USUAL OCCUPATION (TYPE OF WORK) Assistant Director of Administration		12b. KIND OF BUSINESS OR INDUSTRY Atomic Energy Commission	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5113 Viking Road (20814)			
14. FATHER'S NAME FIRST MIDDLE LAST Jeremiah Courtney					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Cannon							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 577-54-2589			17. INFORMANT ADDRESS Thomas A. Courtney, Jr., Son, 2100 Thomas View Rd., Reston, Virginia						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. } (b) Coronary Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <i>John Tauber</i>				TITLE (SPECIFY) M.D.				MEDICAL EXAMINER DATE SIGNED Oct. 2, 1983				
EXAMINER'S NAME (TYPE OR PRINT) John Tauber, M.D.				ADDRESS 8218 Wisconsin Avenue Bethesda, Maryland								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 6, 1983		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia				
24. FUNERAL DIRECTOR NAME Robert A. Humphrey Funeral Homes, P.A., Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR OCT 5 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>				



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Clarence W Cranford		2a. DATE OF DEATH MONTH DAY YEAR 10 25 83		2b. HOUR 8:15 P	
3. SEX male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6 19 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH S.S.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3604 Tarkington Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clergy		12b. KIND OF BUSINESS OR INDUSTRY Retired
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY Mont.	13c. CITY OR TOWN S.S.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William Cranford		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Joyce Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None		16b. SOCIAL SECURITY NO. 578 50 8246		17. INFORMANT ADDRESS Dorothy Cranford (Wife) Same as 13E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2053 Generalized bone malignancy, probably granulocytic sarcoma. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 mo
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Bronchopneumonia, pancytopenia, multiple pathologic fractures.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/10 , 19 83 , to 10/25 , 19 83 , that (I) (we) last saw the deceased alive on 10.25 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Donald E Dillon M.D.		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10.25.83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD E DILLON, M.D.		22e. ADDRESS 18111 Prince Philip Drive OLNEY, Md. 20832			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/28/83		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Suitland	
23d. LOCATION CITY OR TOWN COUNTY STATE PG Maryland		23e. DATE REC'D. BY REGISTRAR 11/27/83			
24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE John J. Corbett			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon-copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR L. Louise Criswell		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) L. LOUISE CRISWELL		2a. DATE OF DEATH MONTH DAY YEAR 10-25-83	
3. SEX Female		2b. HOUR 12 10^P	
4. RACE White		6. AGE (IN YEARS LAST BIRTHDAY) 78	
5. DATE OF BIRTH MONTH DAY YEAR Jan. 24, 1905		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
7b. CITIZEN OF WHAT COUNTRY? U.S.A.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
10. CITY OR TOWN OF DEATH Bethesda		12b. KIND OF BUSINESS OR INDUSTRY Home	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		13a. STREET ADDRESS 20815	
13a. STATE Md.		13b. COUNTY Montgomery	
13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Oliver W. Grimes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Libbie Wolfkiell	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 171-07-4219	
17. INFORMANT ADDRESS Ch.Ch., Md. 20815		17. INFORMANT Harry E. Criswell, Jr. 15 Farmington Ct.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR ARRHYTHMIA 0389 DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) SEPSIS & MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION STREET CITY OR TOWN COUNTY STATE		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 26, 1983 to OCTOBER 25, 1983 , that (I) (we) lost saw the deceased alive on OCTOBER 25, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Mark F. Weinstein MD		22c. DATE SIGNED 10/25/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK F. WEINSTEIN MD		22e. ADDRESS 91125 Rockville Pike Rockville	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/29/83	
23c. NAME OF CEMETERY OR CREMATORY Alto Rest Park Cem.		23d. LOCATION (GIVE ROAD NUMBER) COUNTY Altoona, PA	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash., DC 20016		25a. DATE REC'D. BY REGISTRAR OCT 31 1983	
25b. REGISTRAR'S SIGNATURE Sam J. Conner			

1. Name of the person or organization to whom the letter is addressed.
 2. Address of the person or organization to whom the letter is addressed.
 3. City, State, and Zip Code of the person or organization to whom the letter is addressed.
 4. Date of the letter.
 5. Subject of the letter.
 6. Body of the letter.
 7. Signature of the person or organization sending the letter.
 8. Name and Title of the person or organization sending the letter.
 9. Address of the person or organization sending the letter.
 10. City, State, and Zip Code of the person or organization sending the letter.

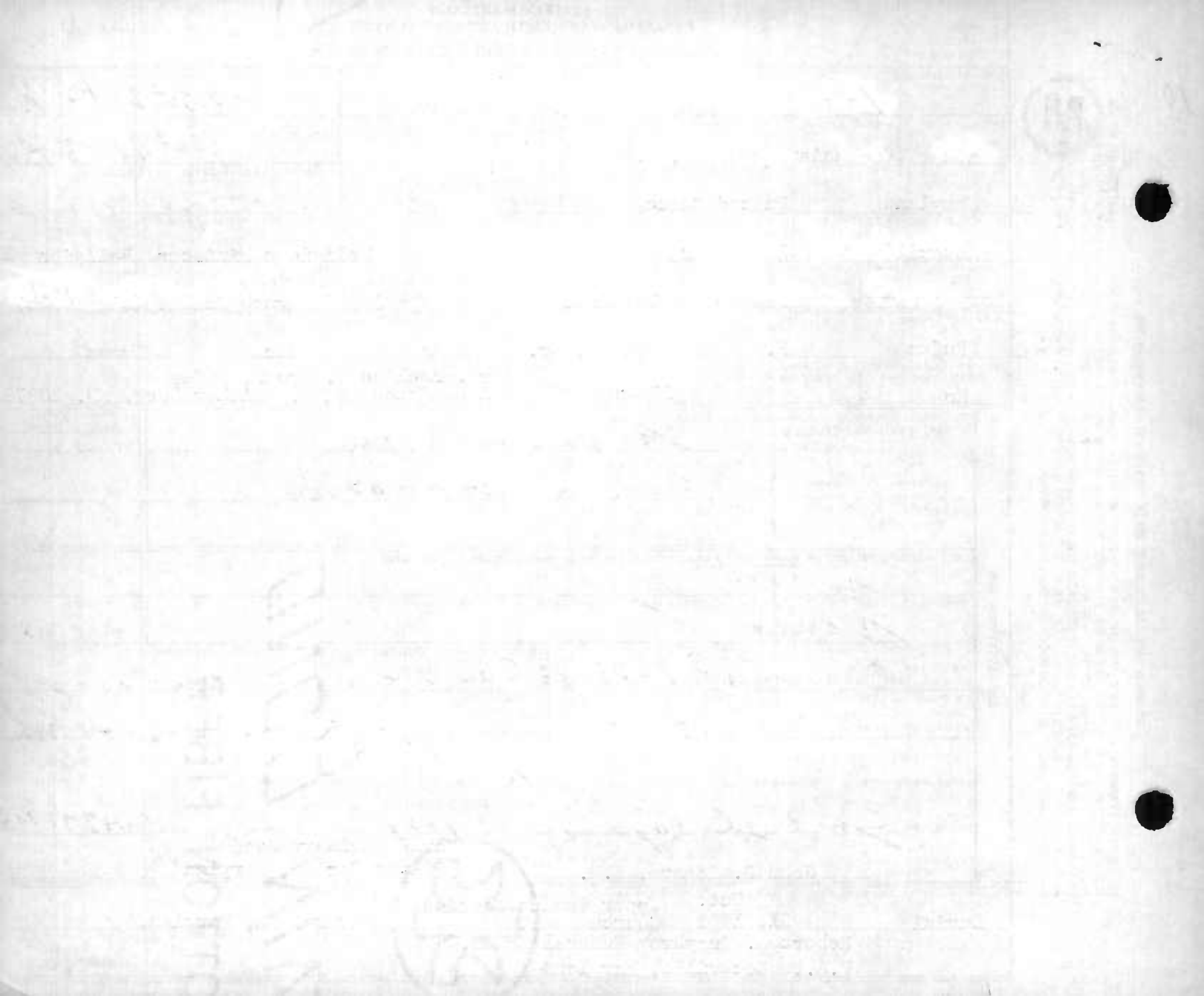
11. Name of the person or organization to whom the letter is addressed.
 12. Address of the person or organization to whom the letter is addressed.
 13. City, State, and Zip Code of the person or organization to whom the letter is addressed.
 14. Date of the letter.
 15. Subject of the letter.
 16. Body of the letter.
 17. Signature of the person or organization sending the letter.
 18. Name and Title of the person or organization sending the letter.
 19. Address of the person or organization sending the letter.
 20. City, State, and Zip Code of the person or organization sending the letter.

21. Name of the person or organization to whom the letter is addressed.
 22. Address of the person or organization to whom the letter is addressed.
 23. City, State, and Zip Code of the person or organization to whom the letter is addressed.
 24. Date of the letter.
 25. Subject of the letter.
 26. Body of the letter.
 27. Signature of the person or organization sending the letter.
 28. Name and Title of the person or organization sending the letter.
 29. Address of the person or organization sending the letter.
 30. City, State, and Zip Code of the person or organization sending the letter.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

STATE OF MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Rufus Edwin Crook, Jr.					2a. DATE KNOWN OF DEATH ESTIMATED Oct 27 1983					2b. HOUR 11 AM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 26, 1939		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN 0 0 0 0		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR Oct. 27 1983		7d. HOUR 11 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT A SUICIDE FACILITY, GIVE STREET ADDRESS) 13002 Carney Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Religious Minister			12b. KIND OF BUSINESS OR INDUSTRY Religion				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13002 Carney Street (Zip: 20906)						
14. FATHER'S NAME FIRST MIDDLE LAST Rufus E. Crook, Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eula Mae Evans					17. INFORMANT ADDRESS Mrs. Pauline W. Crook, Wife, 31 Landsend Drive, Gaithersburg, MD, 20878			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-50-3007											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9520 IMMEDIATE CAUSE (a) Asphyxiation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Carbon Monoxide DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): None													
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR P.M. MONTH DAY YEAR 10:00 P.M. 10 19 83				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Car engine running					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Crook St. Rockville Mont. Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) M.D.				MEDICAL EXAMINER 1919 Seminary Road				DATE SIGNED Oct 27 1983	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS Silver Spring, Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Oct. 31, 1983		23c. NAME OF CEMETERY OR CREMATORY Upper Seneca Baptist Church Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Germantown, Maryland			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR NOV 2 1983				25b. REGISTRAR'S SIGNATURE John J. Corbitt					



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) RICHARD GRENVILLE CROSS, JR			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 6 1983			2b. HOUR 12:25 P _M			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JUNE 4 1920		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSOURI		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S.A.F.	
13a. STATE VIRGINIA		13b. COUNTY FAIRFAX		13c. CITY OR TOWN GREAT FALLS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9220 HIDDEN CREEK DRIVE 99999	
14. FATHER'S NAME FIRST MIDDLE LAST RICHARD GRENVILLE CROSS, SR.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN ESTELLE FULLER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 1941-1975		17. INFORMANT ADDRESS DOROTHY E. CROSS, 9220 HIDDEN CREEK DRIVE.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

1889 IMMEDIATE CAUSE (a) METASTATIC TRANSITIONAL CELL CARCINOMA OF THE BLADDER

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from AUGUST 17, 19 83, to OCTOBER 6, 19 83, that (I) (we) last saw the deceased alive on OCTOBER 6, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (Initials) (did not view the body after death).

22a. SIGNATURE <i>B. Chernow</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 70 Oct 83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. CHERNOW, LCDR, MC, USNR				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 11, 83		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia	
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24. FUNERAL DIRECTOR NAME Money & King Vienna Fun'l Hm, 171 W. Maple Ave		ADDRESS Vienna, Va		25a. DATE REC'D BY REGISTRAR OCT 11 1983		25b. REGISTRAR'S NAME <i>John E. Carver</i>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 2 7 0 3 8	
1. FOR STATE REGISTRAR		78								REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST Louise		MIDDLE Edith		LAST Crown		2a. DATE OF DEATH MONTH DAY YEAR 10-31-83		2b. HOUR 7:05P ^M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 23 1890		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accounting Clerk		12b. KIND OF BUSINESS OR INDUSTRY N.E.A.					
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 400 E. Franklin Avenue 20901			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Deakins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Kiefer		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-44-2396		17. INFORMANT Granddaughter Carolyn J. Cecotti West Mifflin, Pa. 15122			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> <u>5990</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Dehydration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Urinary Tract Infection</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10-25-83</u> <u>10-25-83</u> <u>10-25-83</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CHF, Lewy's of senility, Senile Dementia, ASCVD</u>											
19a. DATE OF OPERATION <u>None</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <u>NO</u> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) the hospital attended the deceased from <u>4/12/79</u> to <u>10/31/83</u> , that (2) the last saw the deceased alive on <u>10-31-83</u> , and that in my <u>own</u> opinion death occurred on the date and hour and from the causes stated above.											
22b. SIGNATURE <u>GB Patrick III MD</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>10-31-83</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GB Patrick III MD</u>		22e. ADDRESS <u>4221 Colesville Rd Silver Spring, Md 20910</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Nov. 3, 1983</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Silver Spring Mont. Md.</u>					
24. FUNERAL DIRECTOR NAME <u>Francis J. Collins</u>		ADDRESS <u>500 University Blvd., W. Silver Spring, Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>NOV 5 1983</u>		25. REGISTRAR'S SIGNATURE <u>John J. Carver</u>					

BP

8 3 2 7 6 3 9

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Claude		MIDDLE C.		LAST Crutchfield		2a. DATE OF DEATH MONTH DAY YEAR 10-6-83		2b. HOUR 3:50 PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 11 1913		6. AGE (IN YEARS LAST BIRTHDAY) 69 yrs.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 74 HRS. HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		10. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
13. CITY OR TOWN OF DEATH Takoma Park		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Adventist Hosp.		15a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Musician		15b. KIND OF BUSINESS OR INDUSTRY -					
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Md.		16b. COUNTY Pr. Geo.		16c. CITY OR TOWN Landover		16d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16e. STREET ADDRESS 6103 - Osborne Rd. 20785			
17. FATHER'S NAME FIRST MIDDLE LAST Robert J. Crutchfield		18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Molly C. Steffie									
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		19b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		20. INFORMANT Dorothy V. Crutchfield - above		20a. ADDRESS Baltimore					
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1619 IMMEDIATE CAUSE (a) <i>myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>hypertension, coronary atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: (c) <i>hypertension, coronary atherosclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <i>hypertension, coronary atherosclerosis</i>											
22a. DATE OF OPERATION		22b. CONDITION FOR WHICH OPERATION WAS PERFORMED		22c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		22d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
24a. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		24b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		24c. LOCATION STREET CITY OR TOWN COUNTY STATE							
25. I certify that (I) this hospital attended the deceased from <i>10/6</i> 19 <i>83</i> to <i>10/6</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>10/6</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (that) (did not) view the body after death.											
26. SIGNATURE <i>Dr. H. R. Brown</i>		26a. DEGREE		26b. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		26c. DATE SIGNED <i>10/13</i>					
27a. PHYSICIAN'S NAME (TYPE OR PRINT)		27b. ADDRESS									
28a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		28b. DATE 10/10/1983		28c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		28d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.					
29. FUNERAL DIRECTOR NAME Nalley's F.H. Inc.		29a. ADDRESS Mt. Rainier, Md.		29b. DATE REC'D. BY REGISTRAR OCT 13 1983		29c. REGISTRAR'S SIGNATURE <i>John J. Carter</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the files. After death has been pronounced, the body should be placed in the casket, and the casket should be closed. The body should be placed in the casket with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 27640			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Mildred B. Culbertson</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>10 30 83</i>			
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>August 23, 1886</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>97</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Collingswood Nursing Center</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Herman Held</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bertha Stace</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO <i>185-36-3041</i>		17. INFORMANT ADDRESS <i>Elizabeth E. Green, Daughter, Same as #13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro vascular accident</i> <i>4360</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>ARTERIOSCLEROTIC CORONARY DISEASE</i> (c) <i>MI</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>✓</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>8/30/82</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <i>10/30/83</i>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>10/30/83</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>10/30/83</i> to <i>10/30/83</i> , that (I) (we) last saw the deceased alive on <i>10/30/83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (not) view the body after death.							
22b. SIGNATURE <i>Thos B. Ward</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>10/30/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Thos B. WARD 6116 Belmar, Bethesda, Md 20817</i>		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal/Burial</i>		23b. DATE <i>October 30, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mount Moriah</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Philadelphia, Pennsylvania</i>	
24. FUNERAL DIRECTOR NAME <i>Robert A. Pumphrey</i>		FUNERAL HOMES, P.A., <i>Rockville, Maryland</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 2 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Linn</i>	

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Elizabeth Fennessey Cummings			2a. DATE OF DEATH MONTH DAY YEAR 10-12-83			2b. HOUR 535 P			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 28, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 92		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker Ret		12b. KIND OF BUSINESS OR INDUSTRY At Home	
13a. STATE None		13b. COUNTY None		13c. CITY OR TOWN Washington D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5425 Western Ave., N.W.	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES FENNESSEY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH McCOURT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT Ann F. Bergquist, Niece		ADDRESS 5601 Springfield Drive Bethesda Md. 20816			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4439 IMMEDIATE CAUSE (a) Pneumonia and Sepsis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) amputation right leg DUE TO, OR AS A CONSEQUENCE OF (c) peripheral vascular disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9-7 , 19 83 , to 10-12 , 19 83 , that (I) (we) lost saw the deceased alive on 10-12 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE James Brodsky MD						DEGREE MD		22c. DATE SIGNED 10-12-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James Brodsky MD						22e. ADDRESS 4701 Willard Ave. Chevy Chase			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE Oct. 15, 1983		23c. NAME OF CEMETERY OR CREMATORY Mount St. Mary's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Flushing, New York		
24. FUNERAL DIRECTOR NAME W.W. Chambers Co. 8655 Georgia Ave., Silver Spring, Md.						25a. DATE REC'D. BY REGISTRAR OCT: 19 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mattie M. Dancey				2b. HOUR 452 p.m.			
3 SEX Female		4 RACE Negro		5 DATE OF BIRTH MONTH DAY YEAR April 23, 1911		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Edgar Lewis		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edmonia Turner		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-46-7489	
17 INFORMANT Thomas Johnson, Fredericksburg, Va.		18. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1516 Princess Anne St.		19. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fredericksburg, Va.		20. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5860 Cardiac-respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction or Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Decompression, possible ruptured vessel				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs 11+ hrs. 3-4 days			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7 AM 10/13/85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 7 AM 10/13/85		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 314 University Blvd Silver Spring Md 20901			
22a. I certify that (I) (this hospital) attended the deceased from 10/13/85 to 4:52 PM 10/13/85 , that (I) (we) last saw the deceased alive on 10/13/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Steven Oristian M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/13/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven ORISTIAN M.D.		22e. ADDRESS 314 University Blvd Silver Spring Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct 16, 1983		23c. NAME OF CEMETERY OR CREMATORY Family Plot		23d. LOCATION CITY OR TOWN COUNTY STATE Spotsylvania, Va. 20101	
24. FUNERAL DIRECTOR NAME Weldon L Bailey		1207 White St Fredericksburg, Va.		25. DATE REC'D. BY REGISTRAR NOV 1 5 1983		25. REGISTRAR'S SIGNATURE John J. Carver	

BP

DHMH-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
ELMORE ELKINS DAVIDSON				OCTOBER 30 1983		2:45 ^a M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.
MALE	CAUCASIAN	SEPTEMBER 25 1904		79			
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
TENNESSEE	UNITED STATES			MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA	NAVAL HOSPITAL		RETIRED		U. S. NAVY		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS			
MARYLAND	PRINCE GEORGE'S	RIVERDALE		4707 RIVERDALE ROAD 20737			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
JOHN L. DAVIDSON		MAUD S. MOORE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
YES		1926-1956		LONA D. DAVIDSON, 4707 RIVERDALE ROAD, RIVERDALE, MD 20737			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> 4275							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 8</u> , 19 <u>83</u> , to <u>OCTOBER 30</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>OCTOBER 30</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT)				22c. DATE SIGNED		22d. ADDRESS	
PETER S. GILL, LT, MC, USNR				31 OCT 83		NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		11/3/83	Arlington Cemetery		Arlington Va.		
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Hines/Rinaldi Funeral Home 11800 New Hampshire Ave. S.S. Md.				OCT 31 1983		John J. Smith	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

PLANT INDUSTRY		PLANT INDUSTRY	
1	2	3	4
5	6	7	8
9	10	11	12
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17	18	19	20
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53	54	55	56
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93	94	95	96
97	98	99	100

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

REG. NO.

1. FOR
STATE
REGISTRAR

Edward

J.

Davis

1. DECEASED NAME
(TYPE OR PRINT)

Edward

J.

Davis

2a. DATE OF DEATH

10 19 83

2b. HOUR

3⁰⁰ 4 M

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

Sept. 27, 1908

6. AGE (IN YEARS LAST BIRTHDAY)

75

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery

MD.

10. CITY OR TOWN OF DEATH

Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Bethesda Health Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Bus Driver

12b. KIND OF BUSINESS OR INDUSTRY

Bus Co.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md. 20814

13b. COUNTY

Montgomery

13c. CITY OR TOWN

Bethesda

13d. INSIDE CITY LIMITS?

YES ☐ NO ☐

13e. STREET ADDRESS

5721 Grosvenor Lane

20814

14. FATHER'S NAME

Matthew

MIDDLE

J.

LAST

Davis

15. MOTHER'S MAIDEN NAME

Ella

MIDDLE

(Unknown)

LAST

(Unknown)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

217-10-6178

17. INFORMANT

ADDRESS

N.C.
Knox Morrison, Rt 9, Box 415B, Statesville,

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1850

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

severe atherosclerotic vascular disease

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED

(ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY

(AT HOME STREET FACTORY OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (1) (this hospital) attended the deceased from Dec 1982, to Oct 19 1983, that (1) (we) last

saw the deceased alive on Oct 17 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above (1) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Barbara Blaylock, M.D.

DEGREE

ATTENDING

PHYSICIAN ☒

MEDICAL

DIRECTOR ☐

STAFF

PHYSICIAN ☐

22c. DATE SIGNED

10-19-83

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Barbara Blaylock, M.D.

22e. ADDRESS

Grill Executive Blvd, Rockville, Md 20852

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

10/22/1983

23c. NAME OF CEMETERY OR CREMATORY

St. Mary's Burial Pk.

23d. LOCATION

CITY OR TOWN

Cumberland, Md.

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

Joseph Gawler's Sons, Inc.

ADDRESS

5130 Wisc. Ave. N.W. Wash., DC 20016

25a. DATE REC'D. BY REGISTRAR

OCT 25 1983

25b. REGISTRAR'S SIGNATURE

John J. Gawler

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) IDA SYLVIA DAVIS			2a. DATE OF DEATH MONTH DAY YEAR 10-15-83			2b. HOUR 9:50 P.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 9, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 85		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASHINGTON				12a. USUAL OCCUPATION (TYPE AS WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS VARSOVSKY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HILDA POTLOK			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO			
17a. SOCIAL SECURITY NO. 577-09-4771			17. INFORMANT ADDRESS 12624 EASTBOURNE DRIVE EUNICE GREENBLAT, SILVER SPRING, MARYLAND						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

ACUTE RESPIRATORY FAILUREAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**24 HOURS**

9120
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **BRONCHOPNEUMONIA**

DUE TO, OR AS A CONSEQUENCE OF

(c) **ASPIRATION**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

CEREBRAL THROMBOSIS; DIABETES MELLITUS

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 10/15/83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE D.D. PATEL		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/16/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.D. PATEL				22e. ADDRESS 6121 MONTROSE RD, ROCKVILLE, MD.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/17/1983		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN		23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH, VIRGINIA	
24. FUNERAL HOME NAME ADDRESS HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.				25. DATE REC'D. BY REGISTRAR OCT 19 1983			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Handwritten mark resembling a stylized 'C' or 'D'.

Handwritten text, possibly '11/11'.

Handwritten text, possibly '20/20'.

Handwritten text, possibly '11/11'.

Handwritten text, possibly '20/20'.

Handwritten text, possibly '11/11'.

Handwritten text, possibly '20/20'.

Handwritten text, possibly '11/11'.

Handwritten text, possibly '20/20'.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR 1- STATE REGISTRAR		27646											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSA ANN DAVIS										2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10-1-83 19		2b. HOUR M	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 8 21 06		6. AGE (IN YEARS) LAST BIRTHDAY 77 YRS		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 10-1-83 19		2d. HOUR 4:10 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Takoma				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic				12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Montgomery				13c. CITY OR TOWN Takoma Pk.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 7605 16th Avenue 20912			
14. FATHER'S NAME FIRST MIDDLE LAST William Reed						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Newsome							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 223-54-0356				17. INFORMANT ADDRESS 7605 16th Ave Gertrude Sanford Takoma Pk., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Dennis F. Smyth M.D.				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 10-2-83	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10/6/83		23c. NAME OF CEMETERY OR CREMATORY Family Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Montross, Va.			
FUNERAL DIRECTOR NAME Granville E. Fisher, Jr.				ADDRESS Maryland Courtesy Center 4011 Harms, Va.				25a. DATE REC'D. BY REGISTRAR OCT 10 1983				25b. REGISTRAR'S SIGNATURE John J. Gault	

OTHER PLACES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP.

DHMM-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST ROY MIDDLE E. E. LAST DAVIS		2. DATE OF DEATH		MONTH 10 DAY 17 YEAR 83		2b. HOUR 5:55 AM	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH		MONTH 3 DAY 16 YEAR 05		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Sandy Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Friends Nursing Home		12r. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber		12b. KIND OF BUSINESS OR INDUSTRY PLUMBING			
13a. STATE MARYLAND		13b. COUNTY Montgomery		13c. CITY OR TOWN Sandy Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1720 Quaker Lane	
14. FATHER'S NAME ALBERTUS		MIDDLE PRESLEY LAST DAVIS		15. MOTHER'S MAIDEN NAME HENRIETTA		MIDDLE STREAM LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR (UNKNOWN)) NO		16b. SOCIAL SECURITY NO 216-05-7843		17. INFORMANT Frances P. Davis		ADDRESS Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure (c) Asthma on the CV system								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) After hemiparesis stroke									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 65 to 10/17/83, that (I) (we) last saw the deceased alive on 10/17/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/17/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. H. Riggs		22e. ADDRESS 1811 P. Philip Dr. Olney, Md 20832							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 19, 1983		23c. NAME OF CEMETERY OR CREMATORY Burtonsville Union		23d. LOCATION CITY OR TOWN COUNTY STATE Burtonsville Mont. Md.			
24. FUNERAL DIRECTOR FRANCIS H. BARBER		LAYTONSVILLE, MD. 20879		25a. DATE REC'D. BY REGISTRAR OCT 21 1983		25b. REGISTRAR'S SIGNATURE John J. Conner			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 2.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		MONTH DAY YEAR		HOUR MIN.	
CLIFTON J DAY								10 29 83		1:10 AM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR		8 UNDER 24 HRS	
Male		Caucasian		July 12 1900		83 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		United States				Montgomery County, MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville		Rockville Nursing Home						Salesman		Automobile	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS			
Maryland				Montgomery		Derwood		6501 Sweetwater Dr. Zip: 20855			
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Remy J DAY				Martha J. GRAY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
No				578-01-0478		Mrs. Janet P. Bishop, Niece, Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1509 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma of the esophagus</u>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY* YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6-2</u> , 19 <u>77</u> , to <u>10-29</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>10-14</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
<u>K.B. Kim</u>				MD.				10-29-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
KWANG S. KIM				1119 Rockville Pike, Rockville MD. 20855							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				October 31, 1983		Forest Oak Cemetery		Gaithersburg Maryland			
24 FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland				NOV 2 1983				<u>Joan J. Canine</u>			

21

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH: 16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Annir Rochelle Dean			2a. DATE OF DEATH MONTH DAY YEAR 10-20-83			2b. HOUR 4:20A M			
3. SEX Female		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 9 23 1895		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 88	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker, Ret		12b. KIND OF BUSINESS OR INDUSTRY At Home	
13a. STATE md		13b. COUNTY P.G.		13c. CITY OR TOWN Adelphi		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1801 Metzzerott Road	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE HARMEN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUCY GLENN EVANS				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO None	
16b. SOCIAL SECURITY NO. 259-07-5980				17. INFORMANT Mrs. Rose M. Gossett, Dr.				ADDRESS 4800 Lexington Ave., Beltsville Md. 20705	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4589 Acute Aspiration Pneumonia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10-20-83	
DUE TO, OR AS A CONSEQUENCE OF (b) Dehydration								10-20-83	
DUE TO, OR AS A CONSEQUENCE OF (c) Aspiration								10-20-83	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Renal Insufficiency, ASCVD, Senile Dementia, HBP									
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (If in this hospital) attended the deceased from 8-13-79 , 19____, to 10/20/83 , 19____, that (If not last saw the deceased alive on 10/19/83 , 19____, and that in my opinion death occurred on the date and hour and from the causes stated above (If did not view the body after death).									
22b. SIGNATURE J B Patrick MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-20-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) 6 B Patrick MD						22e. ADDRESS 9225 Colesville Rd Silver Spring, Md 20910			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Oct. 21, 1983		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. City Md.		
24. FUNERAL DIRECTOR NAME W.W. Chambers Co. 8655 Georgia Ave S.S. Md 20910						25a. DATE REC'D. BY REGISTRAR OCT 24 1983		25b. REGISTRAR'S SIGNATURE R. J. Canfield	

10-20

20

10-20

10-20

10-20

88

78

68

58

48

38

USA

USA

USA

USA

Help Cross the Gulf

Help Cross the Gulf

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) Helen M Deitz			2a. DATE OF DEATH MONTH DAY YEAR 10-17-83			2b. HOUR 5:20 P.M.				
1. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR November 9, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Prin. Geos		13c. CITY OR TOWN Seabrook		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Robert C. Withers					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Jacobs					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-26-7770		17. INFORMANT ADDRESS Edgar B. Deitz (Same as # 13 above)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) RHP FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) SWEET CUPD DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 10 1/2										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a ASUD										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (or this hospital) attended the deceased from 20 MAR 1983 to 17 OCT 1983, that (we) last saw the deceased above on 17 OCT 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)										
22b. SIGNATURE J. K. ELMAN						DEGREE		22c. DATE SIGNED		
23a. PHYSICIAN'S NAME (TYPE OR PRINT)						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
23b. ADDRESS 6721 Belvoir Rd, Nantuxy Rd										
23a. BURIAL, CREMATION, REMOVAL (CHECK!) Burial			23b. DATE 10/20/83		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Maryland.			
24. FUNERAL DIRECTOR NAME ADDRESS Takoma Fun'l Home, Inc. Wash, D.C. 20012						25a. DATE REC'D. BY REGISTRAR 10 1983		25b. REGISTRAR'S SIGNATURE J. J. Carroll		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Takoma "nu'i Home, Inc. Wash. D.C. 20012
Carol J. Carroll 22 N.W.
10/20/83 Rt. Lincoln Conn.
Stewartwood, V.D. Maryland

No 578-25-7770 Edgar H. Belin (Name as in above)

Robert O. Winters
Tulsa
Tulsa
Maryland 21111 Good Samaritan
K 1981 Good Luck 12, 20706
Washington Adventist Hosp. Hometown

Virginia U.S.A.
White November 2, 1912
Montgomery

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Irene NMN Delisi			2a. DATE OF DEATH MONTH DAY YEAR October 12, 83			2b. HOUR 7 23/AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 25, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9407 Bulls Run Parkway 20817	
14. FATHER'S NAME FIRST MIDDLE LAST Phillip Artina				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unobtainable					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (TYPE OR GIVE WAR OR DATES) N/A		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Helen Delisi-daughter-(same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4241 Renal Failure. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) azotemia, congestive heart failure (c) Aortic, Mitral Stenosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: anemia, Impaired Ventricular function.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/11/83 19 to 10/12/83 19, that (I) (we) last saw the deceased alive on 10/11/83 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Miguel A. Rodriguez				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/12/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MIGUEL A. RODRIGUEZ				22e. ADDRESS B31 University Bldg. S.S. Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 15, 1983		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAMES Hines/Rinaldi Funeral Home Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR OCT 13 1983		25b. REGISTRAR'S SIGNATURE John J. Givich			

BP

11800 N.E. Ave.,
 Silver Spring, Md.
 Oct. 12, 1983
 Mr. Harry Gentry, Washington, D.C.

8/4	N/A	579-46-2084	Active	Unobtainable	80817
England	Montgomery	Bethesda	x	8407 Delta Inn Parkway	80817
Maryland	Washington	Adventist Hospital	Horseville	own horse	
Italy	USA	"	Montgomery		
Rumania	White	Oct. 12, 1984	73		

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST
SUSIE ANN DODSON

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
10 26 83 7:15 P.M.

3. SEX

Female

4. RACE

Black

5. DATE OF BIRTH

MONTH DAY YEAR
9 20 80

6. AGE (IN YEARS LAST BIRTHDAY)

63 YRS.

IF UNDER 1 YEAR IF UNDER 23 HRS.

MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

West Virginia

7b. CITIZEN OF WHAT COUNTRY?

United States

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County MD.

10. CITY OR TOWN OF DEATH

Takoma Park

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Washington Adventist Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Housewife

12b. KIND OF BUSINESS OR INDUSTRY

Own home

13a. STATE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

West Virginia

13b. COUNTY

Mercer

13c. CITY OR TOWN

Bluefield

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

309 Reese Street

24701

14. FATHER'S NAME

FIRST MIDDLE LAST
Willie

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST
Josephine

(Unavailable)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

no

16b. SOCIAL SECURITY NO.

Unavailable

17. INFORMANT

ADDRESS

Marshall Dodson, Same as 13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4254

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Cardiomyopathy collapse

Cardiomyopathy

ischemic heart disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

78-72 hrs

4-6 yrs

4-6 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

renal failure, respiratory failure, diabetes

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/27, 19 83, to 10/26, 19 83, that (I) (we) last saw the deceased alive on 10/26, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) move the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

10/26/83

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

DENNIS FRIGOMAN

22e. ADDRESS

1315 E Dear Park Dr, Galesburg

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

11-1-83

23c. NAME OF CEMETERY OR CREMATORY

Roselawn Memorial Garden

23d. LOCATION

Princeton, West Virginia

24. FUNERAL DIRECTOR

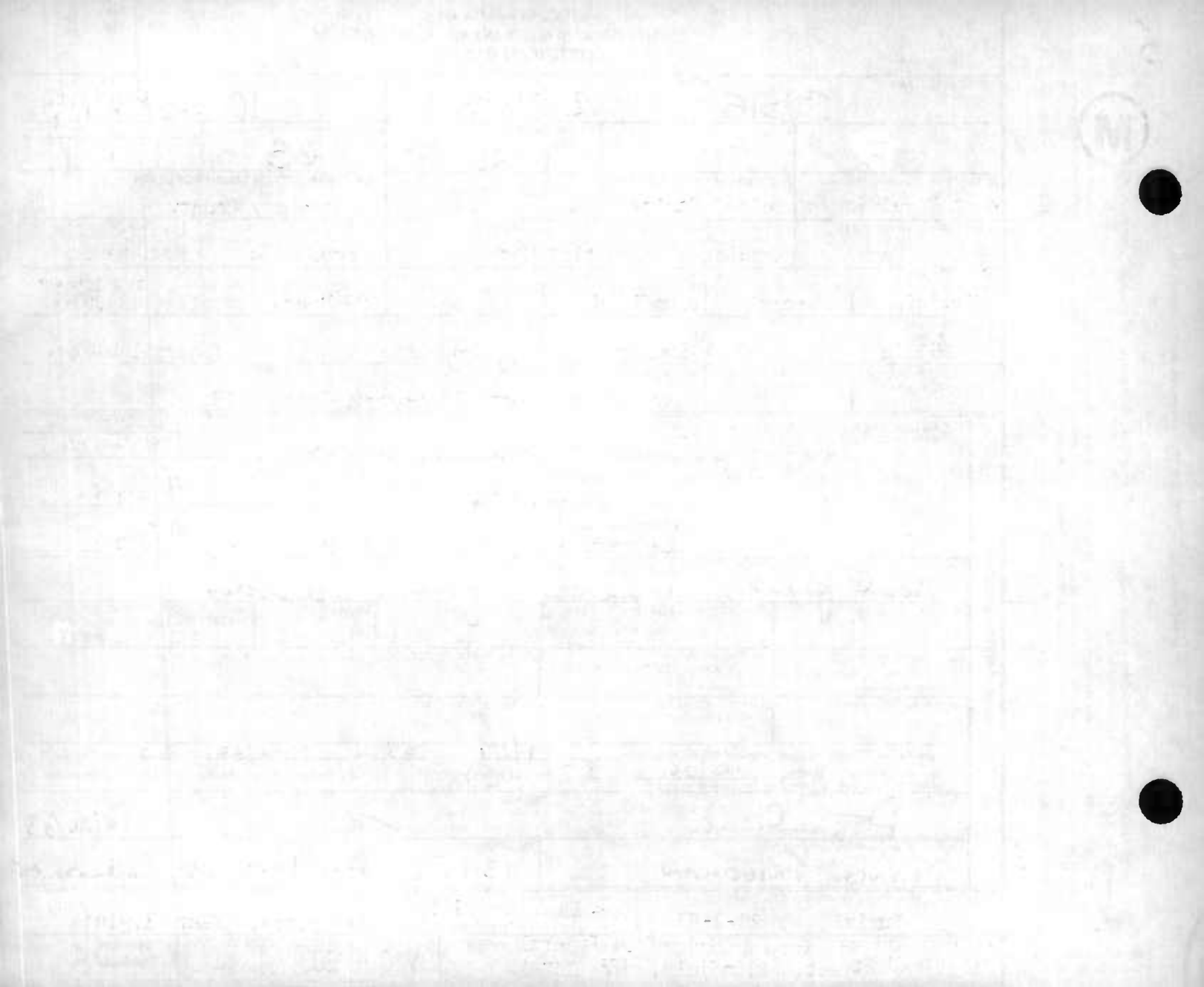
Sinkford & Richardson Funeral Home

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

910 Bland Street, Bluefield, WV 24701

NOV 04 1983

John J. Gough



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83

27653

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Arthur M. Doepp			2a. DATE OF DEATH MONTH 10 DAY 15 YEAR 83 2b. HOUR 9:15p M		
3. SEX Male	4. RACE white	5. DATE OF BIRTH MONTH 10 -DAY 14 -YEAR 98	6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Olney Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Minister	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring NO <input type="checkbox"/>	13d. STREET ADDRESS 3814 Bel Pre Road 20906		
14. FATHER'S NAME FIRST John MIDDLE Doep LAST Doep		15. MOTHER'S MAIDEN NAME FIRST Frances MIDDLE Grupp LAST Grupp			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unknown	16b. SOCIAL SECURITY NO. 215-36-2122	17. INFORMANT Mrs. Evelyn M. Doepp (Same as #13.)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Auto M.I. DUE TO, OR AS A CONSEQUENCE OF (b) ASCD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/15/83 to 10/17/83 , that (I) (we) lost 10/17/83 above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Allan B. Cohan		DEGREE		22c. DATE SIGNED 10/16/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allan B. Cohan, M.D.		22e. ADDRESS 13975 Connecticut Avenue Silver Spring, MD 20906			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10/17/83	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR OCT 25 1983	25b. REGISTRAR'S SIGNATURE John J. Conish

BP



Arthur

M.

Robert

10 11 2 196

Male

Montgomery

Olney W.

Montgomery General Bap.

20000

Mrs. Evelyn M. Doan (dame as 1913)

Received 10/17/83

Eliza, W.

Amos, David

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) AMANDA JEAN DONALDSON			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 13 1983		2b. HOUR 3:32 a.m.
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 7 1983		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 6	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) -		12b. KIND OF BUSINESS OR INDUSTRY -
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY DISTRICT OF COLUMBIA		13c. CITY OR TOWN -	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3418E LACKLAND WAY 99999	
14. FATHER'S NAME FIRST MIDDLE LAST RICKY DALE DONALDSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOANNE RENEE GRAY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. -		17. INFORMANT ADDRESS RICKY D. DONALDSON, 3418E LACKLAND WAY, BOLLING AFB, WASHINGTON, DC 20336	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7513 IMMEDIATE CAUSE (a) ISCHEMIC BOWEL DUE TO, OR AS A CONSEQUENCE OF (b) HIRSCHSPRUNG'S DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) -					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 9, 1983 , to OCTOBER 13, 1983 , that (I) (we) last saw the deceased alive on OCTOBER 13, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. Kendrick		DEGREE MD		22c. DATE SIGNED 14 Oct 83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. KENDRICK, LCDR, MC, USN		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/14/83		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	
23d. LOCATION (CITY OR TOWN) Arlington, Virginia		23e. STATE VA			
24. FUNERAL DIRECTOR'S NAME Person Wheeler Funeral Home, Inc.		24b. ADDRESS 1331 Rockville Pike Rockville, Maryland 20852		25a. DATE REC'D. BY REGISTRAR OCT 19 1983	
25b. REGISTRAR'S SIGNATURE John A. Smith					

22/11/02 121-02

Richard C. Otwell, Jr., Secretary, American Red Cross

Cleared by Dr. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA CECILIA DRISCOLL					2a. DATE OF DEATH MONTH DAY YEAR October 12, 1983				2b. HOUR 9:40A.M.			
3 SEX Female		4 RACE White		5 DATE OF BIRTH Oct. 10, 1891		6 AGE (IN YEARS LAST BIRTHDAY) 92		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD						
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY own home			
13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13225 Locksley Lane 20904	
14 FATHER'S NAME FIRST MIDDLE LAST William Kelley					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jane Crawford							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) N/A		17 INFORMANT ADDRESS Adele Hughes-daughter-(same as 13e)								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Constrictive Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr years years												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Cerebral Vascular Accident</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (the hospital) attended the deceased from 19 <u>60</u> to <u>Oct 12</u> 19 <u>83</u> , that (we) last saw the deceased alive on <u>sep + 8</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did not) view the body after death.												
22b. SIGNATURE <u>Richard Kellogg MD</u> / <u>Stephen N. Jones MD</u> DEGREE ATTENDING PHYSICIAN						22c. DATE SIGNED <u>Oct. 12, 1983</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Kellogg</u> Stephen N. Jones, MD						22e. ADDRESS 809 Viers Mill Rd., Rockville, Md. 20851						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 15, 1983			23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Cherry Hill Camden New Jersey			
24 FUNERAL DIRECTOR Nines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md.						25a. DATE REC'D. BY REGISTRAR OCT 13 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Lohr</u>			

Helen/Elizabeth Funeral Home Silver Spring, Md.
11800 N.W. Ave.

Burial Oct. 15, 1983 Calvary Cemetery Cherry Hill Camden New Jersey

Stephen E. Jones, MD 808 Vista Hill Rd., Rockville, Md. 20851

Oct. 14, 1983

N/A N/A 217-81-0493 Adole Hughes-Hunter-(name as 13e)

William

Malley

Female

Harlyand

Montgomery

Silver Spring tx

13232 Lockley Lane

20304

Silver Spring

Holy Cross Hospital

Honolulu

own home

Pennsylvania

USA

x

Montgomery

Female

White

Oct. 10, 1981

52

October 12, 1983 9:40A.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CHARLES GILBERT DUKES			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 20 1983		2b. HOUR 10:35A
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 26 1925	6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County, MD.		
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED US NAVY		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't Military
13a. STATE SOUTH CAROLINA		13b. COUNTY BERKELEY	13c. CITY OR TOWN SUMMERVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS RT 8 BOX 196 29485
14. FATHER'S NAME FIRST MIDDLE LAST PAUL FRANKLIN DUKES			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE ELIZABETH RICKENBAKER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (U.S. ONLY - YEAR OR DATES) 44-72	17. INFORMANT ADDRESS PHRONTIS NADINE DUKES RT 8 BOX 196 SUMMERVILLE SOUTH		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

2089 IMMEDIATE CAUSE (a) **CARDIAC ARREST**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **RENAL FAILURE**

DUE TO, OR AS A CONSEQUENCE OF

(c) **ACUTE LEUKEMIA**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 21 SEPTEMBER 19 83 , to 20 OCTOBER 19 83 , that (I) (we) last saw the deceased alive on 20 OCTOBER 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Michael Don Canty</i>	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 21 Oct 83
24. PHYSICIAN'S NAME (TYPE OR PRINT) M. D. CANTY LT MC USNR		22e. NAVAL HOSPITAL NAVAL MEDICAL COMMAND NATIONAL CAPITAL REGION BETHESDA MD 20814	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Oct. 24, 1983	23c. NAME OF CEMETERY OR CREMATORY U.S. National Cemetery Beauford, Carolina	23d. LOCATION CITY OR TOWN COUNTY STATE South
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND		25a. DATE REC'D. BY REGISTRAR OCT 25 1983	25b. REGISTRAR'S SIGNATURE <i>John J. Caniel</i>



[Faint, mostly illegible text and markings covering the upper and middle portions of the page. Some words like "RECEIVED" and "OFFICE" are faintly visible.]

[Handwritten text at the bottom of the page, including a signature and date. The signature appears to be "Michael..." and the date is "24/12/80".]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Ruth C Dunbar					2a. DATE OF DEATH MONTH DAY YEAR 10-15-83					2b. HOUR 1:18 P.M.	
3. SEX female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Jan 23, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY None		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS 3315 14th Street, N.E.				
13a. STATE D.C.		13b. COUNTY		13c. CITY OR TOWN Washington							
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Brown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Roberts						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 579-22-7329		17. INFORMANT ADDRESS Mrs. Rosemary R. Figueroa/daughter/same as					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 2859 IMMEDIATE CAUSE (a) Acute Apoptation Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) CVA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) Anemia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10/83 8/83 10/83	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Renal Failure, CHF, ASCVD, CAD, Senile Dementia											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 8-3-83 , 19____, to 10/15/83 , 19____, that (2) I lost the deceased alive on 10/15/83 , 19____, and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (If not, did I not view the body after death.)											
22b. SIGNATURE JBP atuck III MD				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-15-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GB Patrick III MD				22e. ADDRESS 9221 Colesville Rd Silver Spring, Md 20910							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10-19-83		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln			23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Md.		
24. FUNERAL DIRECTOR NAME John T. Rhines Co., 3015 12th St. N.E., D.C. 20002						25a. DATE REC'D. BY REGISTRAR OCT 19 1983		25b. REGISTRAR'S SIGNATURE John J. Carver			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) George J. Dunn					2a. DATE OF DEATH MONTH DAY YEAR October 16 '83					2b. HOUR P. 3:30 M.
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 11 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret'd Engineer		12b. KIND OF BUSINESS OR INDUSTRY Heat & Cool.		
13a. STATE Md.					13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George J. Dunn					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia - Stanton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS 10417 Kardwright Ct. Georgene D. Noffsinger Gaithersburg, Md. 20879			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-VASCULAR Accident</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular disease</u> many yrs DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes mellitus</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 19 81</u> to <u>10/16 83</u> , that (I) (we) last saw the deceased alive on <u>10/13 83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <u>G. Leonard Gold, M.D.</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/17/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Leonard Gold, M.D.					22e. ADDRESS 8630 FENTON ST. #230 SILVER SPRING MD 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/20/83		23c. NAME OF CEMETERY OR CREMATORY Holy Sepulchre Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Totowa Passaic N.J.			
24. FUNERAL DIRECTOR NAME Scanlon Funeral Home					421 ADDRESS 12th Avenue, Paterson, N. J. 07514		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE John J. Smith			

Male	White	May 11 1900
Mr.	U.S.A.	X
Rockville	Shady Grove Adventist Hospital	F
Mr.	Montgomery Gathersburg	X
George	J. Dunn	Julia
No	-	183-10-5650 George D. No

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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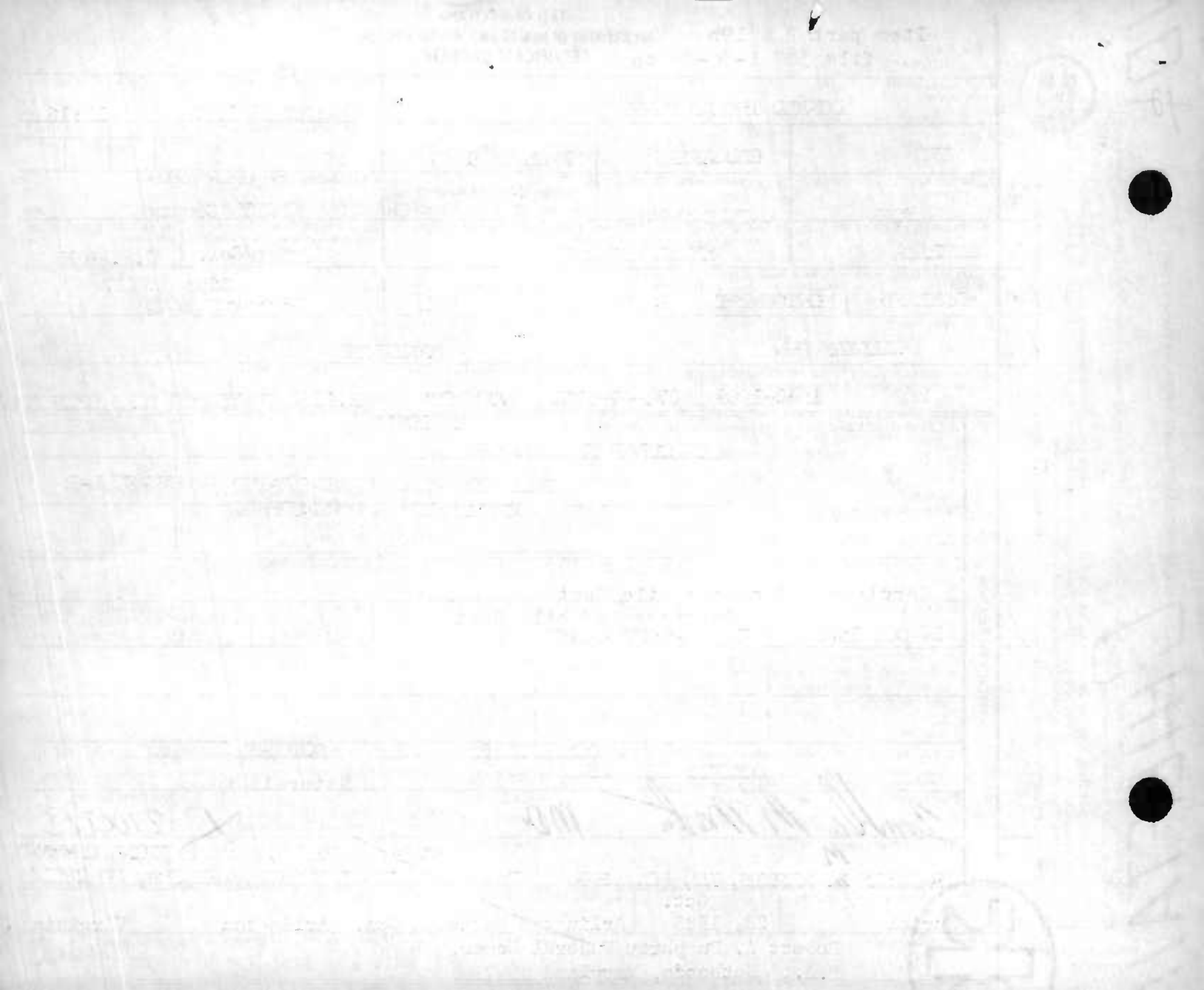
BR 335

FOR Item part 2 & 19b
1- STATE REGISTRAR film 587 1-30-84 cn

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DONALD THOMAS DUNNE			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 26 1983			2b. HOUR 12:16 P.					
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MARCH 25 1917		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED Col.		12b. KIND OF BUSINESS OR INDUSTRY U.S. ARMY			
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM DUNNE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY LIEB			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. 1940-1969		
17. INFORMANT ANTONETTA DUNNE			ADDRESS 6500 GREYSWOOD ROAD, BETHESDA								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>CIRCULATORY COLLAPSE</u> 1561 DUE TO, OR AS A CONSEQUENCE OF (b). <u>POST OPERATIVE DISSEMINATED INTRAVASCULAR COAGULATION AND HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF (c). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause: <u>lost.</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Carcinoma of common bile duct</u>											
19a. DATE OF OPERATION 24 OCT 1983			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of bile duct EXPLORATORY LAPARATOMY				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 16</u> , 19 <u>83</u> , to <u>OCTOBER 26</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased <u>alive</u> on <u>OCTOBER 26</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>Natural</u>											
23a. SIGNATURE <i>Franklin B. Martin</i> MD					DEGREE MD			23b. DATE SIGNED 27 OCT 83		23c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANKLIN B. MARTIN, LT. MC, USNR					23e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 28, 1983		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey			ADDRESS Funeral Homes, P.A., Bethesda, Maryland			25a. DATE REC'D. BY REGISTRAR NOV 2 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Lohr</i>			



BP _____

DHMM - 16 50M 4/82
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Delma M. Dye			2a. DATE OF DEATH MONTH DAY YEAR 10 29 83			2b. HOUR 3:00 AM		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 23, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Dakota		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Advent Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		
12b. KIND OF BUSINESS OR INDUSTRY Elementary School								
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Wilder				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Alberta Bowers				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-48-9404		17. INFORMANT ADDRESS Robert E. Dye, Son, Same as item #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic shock 5698 DUE TO, OR AS A CONSEQUENCE OF (b) Abscissoid Rupture Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours Hours								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								
19a. DATE OF OPERATION 10/28		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Sigmoid Rupture			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 10/26 , 19 83 , to 10/28 , 19 83 , that (I) (we) lost saw the deceased alive on 10/28 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Joel Schuman						22c. DATE SIGNED Oct. 29, 1983		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joel Schuman						22e. ADDRESS 9410 Old Georgetown Rd Bethesda		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE October 30, 1983		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland				25a. DATE REC'D BY REGISTRAR NOV 2 1983		25b. REGISTRAR'S SIGNATURE [Signature]		



CHIEF-MAIL

U.S. COTTON

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph M Edmonds			2a. DATE OF DEATH MONTH DAY YEAR 10-29-83			2b. HOUR MIN. 5:15 AM	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 4 24 06		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gulf Service Station Employed	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James Edmonds		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Starkey		16. STREET ADDRESS 1806 Brisbane Street 20902			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 577-10-1648		17. INFORMANT Lucille M. Edmonds Wife Same as 13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

3320
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **PARKINSONS DISEASE**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9-21 , 19 83 , to 10-29 , 19 83 , that (I) (we) last saw the deceased alive on 10-28 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Norman S. Kouval				DEGREE MD		22c. DATE SIGNED 10-29-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NORMAN S. KOUVAL MD				22e. ADDRESS 8750 GEORGIA AVE SS MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 1, 1983		23c. NAME OF CEMETERY OR CREMATORY George Washington		23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi Pr. Geo. Md.	
24. FUNERAL DIRECTOR NAME Francis J. Collins				25a. DATE REC'D. BY REGISTRAR NOV 2 1983		25b. REGISTRAR'S SIGNATURE John J. Lohr	
500 University Blvd., W. Silver Spring, Md.							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



11/11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified (page 4).

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) MARGARETTE L. ELROD			2a. DATE OF DEATH MONTH DAY YEAR 10-10-1983			2b. HOUR MIN. 11-50 A			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 12, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 90			IF UNDER 1 YEAR MONTHS DAYS YRS.		IF UNDER 24 HRS. HOURS MIN. MD.	
7a. BIRTHPLACE (STATE OR FOREIGN) Missouri		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery						
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Journalist			12b. KIND OF BUSINESS OR INDUSTRY Newspaper			
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 10604 Hayes Ave. 20902		
14. FATHER'S NAME FIRST MIDDLE LAST Theodore A. Lampton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary A. Pickens								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF KNOWN, GIVE WAR OR DATES) N/A		17. INFORMANT Mary Smiraglia				ADDRESS Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Extensive Stroke DUE TO, OR AS A CONSEQUENCE OF (c) Stroke										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. MOTHER'S NAME STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 9/30 19 83 to 10/10 19 83 , that (I) (we) last saw the deceased alive on 10/10 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Penny L. Bisk MD				DEGREE MD				22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PENNY L. BISK MD				22e. ADDRESS 1033 GEORGIA Ave Silver Spring MD								
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Oct. 13		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Siloam Springs, Arkansas						
24. FUNERAL DIRECTOR NAME Lives-Pearson Funeral Home				ADDRESS Arlington, Va. 22201				25a. DATE REC'D. BY REGISTRAR OCT 14 1983		25b. REGISTRAR'S SIGNATURE John J. Gresh		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) MARGARET V Virginia EMMERT				2a. DATE OF DEATH MONTH DAY YEAR 10-10-83			
3. SEX FEMALE				2b. HOUR 2:15 A			
4. RACE Caucasian				5. DATE OF BIRTH MONTH DAY YEAR 7-18-09			
6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA XXXXXXXXXX				7b. CITIZEN OF WHAT COUNTRY? U.S.A.			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner				12b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning			
13a. STATE Maryland				13b. COUNTY Montgomery			
13c. CITY OR TOWN Rockville				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Warren Linwood Slocombe				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Frances Moore			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 578-12-0063			
17. INFORMANT ADDRESS 4704 Bel Pre Road Rockville, Md. 20853				Mrs. Florence E. Sieling - Daughter			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 5621 DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Ruptured sigmoid diverticulum 5 weeks				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 6 weeks							
19a. DATE OF OPERATION 9/8/83				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured sigmoid diverticulum			
19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/7 , 19 83 , to 10/10 , 19 83 , that (I) (we) last saw the deceased alive on 9/7 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W T Marcus MD				22c. DATE SIGNED 10/11/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W T MARCUS MD				22e. ADDRESS 10301 Georgia Ave Silver Spring, Md 20912			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Oct. 12, 1983			
23c. NAME OF CEMETERY OR CREMATORY Gate Of Heaven Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Mont. Maryland			
24. FUNERAL DIRECTOR NAME Francis J. Collins				25a. DATE REC'D. BY REGISTRAR OCT 13 1983			
25b. REGISTRAR'S SIGNATURE John J. Conner				25c. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARTHUR ERDHEIM				2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 11, 1983			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 7, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) INDIANA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY KITCHEN DESIGN	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MARYLAND MONTGOMERY SILVER SPRING				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2409 NEES LANE 20904	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE ERDHEIM				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE WACHS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES NO OR UNKNOWN				16b. SOCIAL SECURITY NO 091-05-9183		17. INFORMANT ADDRESS JOSEPHINE ERDHEIM, SILVER SPRING, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4349 DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hours 15 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Cerebral arteriosclerosis, coronary arteriosclerosis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from JAN. 19 67, to OCT. 11, 19 83, that (I) (we) saw the deceased alive on OCT. 10, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. Arnold A. Lear				DEGREE MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/11/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ARNOLD A. LEAR, M. D.				22e. ADDRESS 2201 L STREET, N. W. WASHINGTON, D. C.			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 10/13/1983		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN, FALLS CHURCH, VIRGINIA		23d. LOCATION FALLS CHURCH, VIRGINIA	
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.				25a. DATE REC'D. BY REGISTRAR OCT 17 1983		25b. REGISTRAR'S SIGNATURE John J. [Signature]	



Examination of books

Good for attention, many with no record

12

11

10

9

OCT 10

10/11/88

X

James C. [unclear]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR AM M	
WILLIAM HENRY		ERSKINE						10 26 83		1:15 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. YEARS UNDER 1 YEAR MONTHS DAYS		8. YEARS UNDER 24 HRS HOURS MIN	
Male		Caucasian		Dec. 6 1908		74 YRS					
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Japan		U.S.A.				Montgomery County, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring		Althia Woodland Nurs. Home		Mathematician		Gov't.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		P.G.		Laurel				8216 Gorman Ave. 20707			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
William Hugh Erskine		Virginia Stewart									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No		N/A		578-32-2247		William Erskine		Same as #13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a):										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4292 ARTERIOSCLEROTIC CARDIOVASCULAR Dis											
DUE TO, OR AS A CONSEQUENCE OF (b):											
GENERALIZED ARTERIOSCLEROSIS											
DUE TO, OR AS A CONSEQUENCE OF (c):											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
RHEUMATIC HEART DISEASE, MITRAL STENOSIS, CHRONIC BRAIN SYNDROME											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from March 19 77 to Oct 83 that (he/she) lost											
saw the deceased alive on Oct 26 19 83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Bernard A. Fitzgerald MD								10-26-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
BERNARD A. FITZGERALD				217 UNIVERSITY BLVD. E; Silver Spring, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Cremation		26 Oct 83		Metropolitan Crem.		Alexandria Va.					
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
FLECK FUNERAL HOME, INC.				OCT 28 1983				John J. Connel			
7601 Sandy Spring Rd. Laurel, Md. 20707											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR						
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST Leroy M EVANS			MONTH DAY YEAR 10 27 83		3:04 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
MALE	BLACK	MAY 9, 1942	41		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.	U.S.A.		MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville	Shady Grove Adventist Hospital		Unemployed			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. CITY OR TOWN	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.	Montg	Garthersburg	YES <input type="checkbox"/> NO <input type="checkbox"/>		20878 Pratherstown Rd.	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
FIRST MIDDLE LAST Samuel Metz EVANS	FLORENCE Matthews		No			
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
216-40-6416		Tony Evans (brother)		508 N. Deer Pk. Ct. Garthersburg Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2866 DUE TO, OR AS A CONSEQUENCE OF (b) Cavernous Sinus Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) DIC + Hepatic Failure						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10-24-1983, to 10-27-1983, that (I) (we) lost saw the deceased alive on 10-27-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE		DEGREE		22c. DATE SIGNED		
R. Shakir		MD		10-27-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
RAMLETH I.A. SHAKIR		Medical Centre Dr. 9715 Suit 102 A, Rockville MD 20850				
23a. BURIAL, CREMATION, REMOVAL		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		11-2-83	Ash Memorial Cem.		Sandy Spring Montg Md	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		
George R. Snowden		246 Ash Wash. St. Rockville Md		NOV 7 1983		

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20% COTTON



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARY T EVANS			2a. DATE OF DEATH MONTH DAY YEAR 10 24 83			2b. HOUR 6:11 A.M.					
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 12 31 08		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (COUNTRY) NASH. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEMAKER		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD			13b. COUNTY MONT		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5202 CROSSFIELD COURT		
14. FATHER'S NAME FIRST MIDDLE LAST ? ? GROSS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ? ?			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 578-16-2718	
17. INFORMANT ADDRESS MARY P. SCHMIDT, 5202 CROSSFIELD CT											

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Insulin dependent diabetes mellitus

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1982 , 19 OCT. 24 19 83 , that (I) (we) lost 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE B. N. ROSENBAUM, M.D.				DEGREE		22c. DATE SIGNED 10/24/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. N. ROSENBAUM				22e. ADDRESS 3720 FARRAGUT AVE. KENSINGTON, MD. 20895			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE OCT 26 1983		23c. NAME OF CEMETERY OR CREMATORY Fair Lakes Cemetery, Brentwood P.A.		23d. LOCATION CITY OR TOWN STATE MD	
24. FUNERAL DIRECTOR NAME Takoma Funeral Home, J. A. Miller, 257 Carroll St. NW, D.C.				25a. DATE REC'D. BY REGISTRAR OCT 27 1983		25b. REGISTRAR'S SIGNATURE John J. Carver	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR										20. DATE KNOWN OF DEATH									
1a. DECEASED NAME (TYPE OR PRINT) FALUSTI										20. DATE KNOWN OF DEATH Oct 22 1983									
3. SEX F										21. DATE PRONOUNCED DEAD Oct 22 1983									
4. RACE W										22. DATE OF OPERATION None									
5. DATE OF BIRTH JULY 12 1896										23. DATE OF OPERATION None									
6. AGE (IN YEARS) 87										24. DATE OF OPERATION None									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IRELAND										25. DATE OF OPERATION None									
7b. CITIZEN OF WHAT COUNTRY? U.S.A.										26. DATE OF OPERATION None									
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										27. DATE OF OPERATION None									
9. BALTIMORE CITY OR COUNTY OF DEATH Montg										28. DATE OF OPERATION None									
10. CITY OR TOWN OF DEATH Pi 7 Spg										29. DATE OF OPERATION None									
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11200 Lockwood Dr Sp 516										30. DATE OF OPERATION None									
12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE										31. DATE OF OPERATION None									
13a. USUAL RESIDENCE (IF NOT IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Montg										32. DATE OF OPERATION None									
13b. STATE MD										33. DATE OF OPERATION None									
13c. CITY OR TOWN Pi 7 Spg										34. DATE OF OPERATION None									
14. FATHER'S NAME LUKE										35. DATE OF OPERATION None									
15. MOTHER'S MAIDEN NAME MARY										36. DATE OF OPERATION None									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO										37. DATE OF OPERATION None									
16b. SOCIAL SECURITY NO. 579-44-2353										38. DATE OF OPERATION None									
17. INFORMANT DAUGHTER										39. DATE OF OPERATION None									
18. ADDRESS BARLOW										40. DATE OF OPERATION None									
19. ADDRESS SAME AS 13										41. DATE OF OPERATION None									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None																			
19a. DATE OF OPERATION None										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE John S. Rogers M.D. Daps MEDICAL EXAMINER										TITLE (SPECIFY) DATE SIGNED Oct 22 1983									
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS, MD.										ADDRESS 1919 SEMINARY RD. SILVER SPRING, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL										23b. DATE OCT. 25, 1983									
23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY										23d. LOCATION CITY OR TOWN SILVER SPRING MONT. MD.									
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS										25a. DATE REC'D. BY REGISTRAR OCT 27 1983									
25b. REGISTRAR'S SIGNATURE John J. Collins																			
500 UNIVERSITY BLVD., W. SILVER SPRING, MD.																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For this purpose, the attending physician and completely filled in by the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.					
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR					
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Madeline C. Fanelli					2b. HOUR P M 12:30 P M					
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR June 2, 1907		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 76 YRS.		7. HOUR P M 12:30 P M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10 CITY OR TOWN OF DEATH Sumner		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4970 Sentinel Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY In Own Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Sumner		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST John Carpentri					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Amadeo					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					16b. SOCIAL SECURITY NO. 218-50-0737		17 INFORMANT ADDRESS Mrs. Anita Kapiloss, Sumner, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) glioblastoma DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) 1919 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 months		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:30 PM 10 27 1983			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 10/1 1982 to present 1983, that (I) (we) last saw the deceased alive on 10/17 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE M. W. Dennis, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/27/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. W. Dennis, M.D.			22e. ADDRESS 3 Wash. Circle, N.W. Wash. D.C. 20037							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-2-1983		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.			
24 FUNERAL DIRECTOR NAME James F. Scarell			ADDRESS Cumberland, Md.			DATE RECD BY REGISTRAR NOV 02 1983				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
Gabriel Farago				10-25-83 2:15 AM			
3 SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		Caucasian		May 4 1921		62 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Hungary		U.S.A.				Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hosp.		Furniture Restorer		Self-Employed	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Montgomery		Wheaton		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS		13f. ZIP CODE	
Gabor Farago		Maria Fodor		11011 Bucknell Drive		20902	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		577-54-0063		Maria Farago		Wife Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRO-VASCULAR DISEASE INVOLVING BRAIN-STEM DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL ARTERIO-SCLEROSIS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 DAYS 5 MONTHS			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 10							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10:24 19 83, to 10/25 83, that (I) (we) lost the deceased alive on above, (I/we) did not view the body after death.		22b. SIGNATURE David Goldentzweig		22c. DATE SIGNED 10/25/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID GOLDENTZWEIG MD		22e. ADDRESS 9801 GEORGIA AVE SILVER SPRING, MARYLAND 20902		22f. ATTENDING PHYSICIAN MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 28, 1983		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont. Md.	
24. FUNERAL DIRECTOR Francis J. Collins 500 University Blvd., W. Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR OCT 27 1983		25b. REGISTRAR'S SIGNATURE John J. Smith	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARGARET ISABEL FARKAS			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 10 1983		2b. HOUR 11:58 P M		
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 9 1926		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. STATE MARYLAND		13b. COUNTY PRINCE GEO		13c. CITY OR TOWN OXON HILL		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD CALVIN DUDLEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST POLLY DAVIS BURNS		13e. STREET ADDRESS 5520 HELMONT DRIVE		20745	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-30-7591		17. INFORMANT ADDRESS DAVID M. FARKAS, 5520 HELMONT DR., OXON HILL.			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

RENAL FAILURE

0389

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **SEPSIS**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from AUGUST 19 , 19 83 , to OCTOBER 10 , 19 83 , that (we) lost saw the deceased alive on OCTOBER 10 , 19 83 , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.							
22b. SIGNATURE <i>J. R. Fletcher</i>				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-12-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. R. FLETCHER, CAPT, MC, USN				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/14/83		23c. NAME OF CEMETERY OR CREMATORY Warm Springs Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Warm Springs Virginia	
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24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		25a. ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25b. DATE REGISTERED OCT 17 1983		25c. REGISTRAR'S SIGNATURE <i>John J. Carver</i>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PAUL FEE			2a. DATE OF DEATH MONTH DAY YEAR 10 7 83			2b. HOUR 21:19 M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 4 27		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired Landscaper			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Derwood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7253 Muncaster Mill Road 20855			
14. FATHER'S NAME FIRST MIDDLE LAST Richard Fee				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachel Milwee							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 225-32-4757		17. INFORMANT ADDRESS Melba V. Fee same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (b), (c), and (d)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Failure 4279 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Obstructive Lung disease DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac overworked APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3/31 , 19 81 , to 10/7 , 19 83 , that (I) (we) lost saw the deceased alive on 10/7 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles W. Kares DEGREE						22c. DATE SIGNED 10/8/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES W. KARES						22e. ADDRESS 15C Deerpark Drive, Gaithersburg					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/10/83		23c. NAME OF CEMETERY OR CREMATORY Bethesda Un. Methodist Church Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Browningsville Maryland			
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852						25a. DATE REC'D. BY REGISTRAR OCT 14 1983			25b. REGISTRAR'S SIGNATURE Dee A. Gail		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
Minerva			Files			October 21, 1983		2:00 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		Black		November 18, 1887		95 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
North Carolina		U.S.A.				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park		Takoma Park Nursing Home		Beautician		Private			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland				Silver Spring		NO		20906 13114 Wilton Oaks Drive	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Information not available			Information not available						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No		578-66-9643		Doris F. Waters, granddaughter, same address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerotic C.V. Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Senility									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) <u>Antonio G. Uy</u> attended the deceased from <u>April 7, 1980</u> , to <u>October 21, 1983</u> , that (I) <u>we</u> last saw the deceased alive on <u>September 15, 1983</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Antonio G. Uy</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Oct. 21, 1983			
22d. PHYSICIAN'S NAME (Type) Antonio G. Uy, M. D.				22e. ADDRESS 831 Univ. Blvd. E, # 25, Silver Spring, Md. 20903					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Oct. 25, 1983		Lincoln Memorial		Suitland, P. G., Maryland			
24. FUNERAL DIRECTOR McGuire Funeral Service, Inc				7400 Georgia Ave. NW, Washington, DC 20012		REC'D BY REGISTRAR 2001 2-7-83		25b. REGISTRAR'S SIGNATURE <u>John Smith</u>	

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

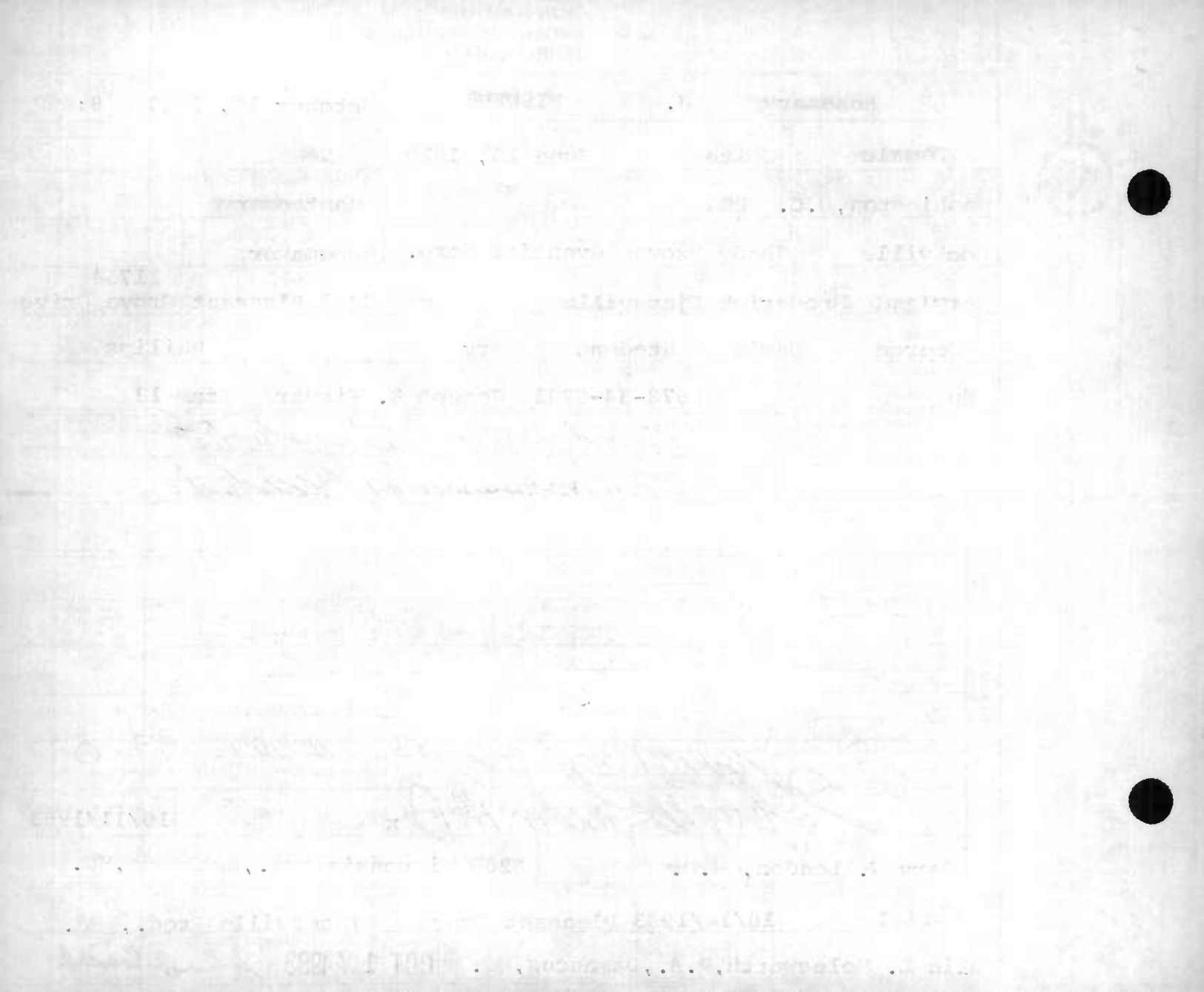
1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of medical examiner		12. Signature of health officer	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of interment place		18. Signature of burial place		19. Signature of burial place		20. Signature of burial place	
21. Signature of burial place		22. Signature of burial place		23. Signature of burial place		24. Signature of burial place	
25. Signature of burial place		26. Signature of burial place		27. Signature of burial place		28. Signature of burial place	
29. Signature of burial place		30. Signature of burial place		31. Signature of burial place		32. Signature of burial place	
33. Signature of burial place		34. Signature of burial place		35. Signature of burial place		36. Signature of burial place	
37. Signature of burial place		38. Signature of burial place		39. Signature of burial place		40. Signature of burial place	
41. Signature of burial place		42. Signature of burial place		43. Signature of burial place		44. Signature of burial place	
45. Signature of burial place		46. Signature of burial place		47. Signature of burial place		48. Signature of burial place	
49. Signature of burial place		50. Signature of burial place		51. Signature of burial place		52. Signature of burial place	
53. Signature of burial place		54. Signature of burial place		55. Signature of burial place		56. Signature of burial place	
57. Signature of burial place		58. Signature of burial place		59. Signature of burial place		60. Signature of burial place	
61. Signature of burial place		62. Signature of burial place		63. Signature of burial place		64. Signature of burial place	
65. Signature of burial place		66. Signature of burial place		67. Signature of burial place		68. Signature of burial place	
69. Signature of burial place		70. Signature of burial place		71. Signature of burial place		72. Signature of burial place	
73. Signature of burial place		74. Signature of burial place		75. Signature of burial place		76. Signature of burial place	
77. Signature of burial place		78. Signature of burial place		79. Signature of burial place		80. Signature of burial place	
81. Signature of burial place		82. Signature of burial place		83. Signature of burial place		84. Signature of burial place	
85. Signature of burial place		86. Signature of burial place		87. Signature of burial place		88. Signature of burial place	
89. Signature of burial place		90. Signature of burial place		91. Signature of burial place		92. Signature of burial place	
93. Signature of burial place		94. Signature of burial place		95. Signature of burial place		96. Signature of burial place	
97. Signature of burial place		98. Signature of burial place		99. Signature of burial place		100. Signature of burial place	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																			
1. FOR STATE REGISTRAR			REG. NO.																
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Rosemary			J.					FISHER		October 10,		1983				8:45P _M			
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS				
Female			White			June 15, 1929			54			MONTHS			DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH										
Washington, D.C.			USA						Montgomery MD.										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Rockville			Shady Grove Adventist Hosp.									Homemaker							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS							
13a. STATE										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21754							
13b. COUNTY												3481 Pleasant Grove Drive							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME									
George David Stedman										Mary Philips									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR (HANDOWN))										16b. SOCIAL SECURITY NO.									
No										578-34-9203									
17. INFORMANT										ADDRESS									
Joseph H. Fisher										Item 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest																			
4360																			
DUE TO, OR AS A CONSEQUENCE OF																			
Cerebrovascular Accident																			
DUE TO, OR AS A CONSEQUENCE OF																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																			
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY?										20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNEXPECTED <input type="checkbox"/> OR CONTRIBUTED TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR									
										P.M. 19									
21c. INJURY OCCURRED										21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
WHIP <input type="checkbox"/> NOT WHIP <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. LOCATION CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 10/10/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) see the body after death.										19 83 to 10/10/83 that (I) (we) last									
22b. SIGNATURE										22c. DATE SIGNED									
Gary W. London M.D.										10/11/1983									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS									
Gary W. London, M.D.										8200 Wisconsin Ave., Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE									
Burial										10/14/1983									
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION CITY OR TOWN COUNTY STATE									
Pleasant Grove										Ijamsville Fred., Md.									
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR									
Olin L. Molesworth, P.A., Damascus, Md.										OCT 17 1983									
25b. REGISTRAR'S SIGNATURE																			
John J. Casper																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James D. Flaherty			2a. DATE OF DEATH MONTH DAY YEAR 10-3-83		2b. HOUR MIN. 10:20 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept., 5, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cincinnati, Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) C.P.A.		12b. KIND OF BUSINESS OR INDUSTRY S.E.C.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Maryland Frederick Ijamsville				13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 2733 Hillside Ct. 21754	
14. FATHER'S NAME FIRST MIDDLE LAST Dennis Flaherty				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Kelly			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W W I US Ar 056-07-8572		17. INFORMANT ADDRESS Robert C. Wrigley, 1083 Peralta Ave. Albany, Calif. 94076			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4860 IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —			
22a. I certify that (I) (this hospital) attended the deceased from July 8, 1983 , to 10-5, 1983 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 10/3, 1983 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE James W. Egan M.D.				DEGREE —		22c. DATE SIGNED 10/3/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James W. Egan				22e. ADDRESS 5413 Cedar Ln - Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Oct. 4, 1983		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.	
24. FUNERAL DIRECTOR NAME ADDRESS Lee Funeral Home, 300 4th St. N.E., Wash. D.C.				25a. DATE REC'D. BY REGISTRAR OCT 6 1983		25b. REGISTRAR'S SIGNATURE John J. Carver	

BP

Lee Funeral Home, 300 1st St. N. W., Wash. D. C.

Operation • Oct. 1, 1983 Lee's Crematory Washington D. C.

Yes

W. I. US # 050-CY-0572

George D. Wright, 1003 Parker Ave.

Dennis

Flanery

May

2.

Kelly

Alamy, C. L. 1000

Barbara

Frederick I. Maville

2733 Hillside Ct.

Male

White

Oct. 1, 1987

60

Cincinnati, Ohio • U.S.A.

U.S.A. •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) MARIAN C. FLAHERTY					2a. DATE OF DEATH MONTH 10 DAY 2 YEAR 83 2b. HOUR 9:00 AM				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 12 DAY 22 YEAR 95		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Buffalo, N.Y.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) POTOMAC Valley N. H.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY at home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Frederick 13c. CITY OR TOWN Ijamsville					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2733-Hillside Court 21754		
14. FATHER'S NAME FIRST Charles MIDDLE F.J. LAST Wrigley			15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE S. LAST Pickering						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 577-84-3623		17. INFORMANT ADDRESS Charles Y. Wrigley (Nephew) Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1790 IMMEDIATE CAUSE (a) Cancer of uterus DUE TO, OR AS A CONSEQUENCE OF (b) Metastases DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Coronary artery disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8-25-19-83 to 10-2-19-83 , that (I) (we) last saw the deceased alive on 9-18-19-83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE H. Baker		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-2-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HADI BAHAR MD				22e. ADDRESS 8218 W's cousin Ave. Bethesda					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Oct. 3, 1983		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN Washington, D.C. COUNTY STATE			
24. FUNERAL DIRECTOR NAME J. William Lee's Sons Co.		ADDRESS 300-4th St., NE, Wash., DC		25a. DATE REC'D. BY REGISTRAR 20002 OCT 6 1983		25b. REGISTRAR'S SIGNATURE John J. Connel			

BP

J. William Lee's Sons Co. 300-4th St., Wash., D.C.
Oct. 3, 1963 Lee's Creamery
Washington, D.C.

577-84-3-63 Charles Y. Lee (he has) and as 13

Charles F. L. Mary

Barryman Frederick I. Amaville

onville

United States

Washington

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Alice S. Flory			2a. DATE KNOWN OF DEATH ESTIMATED Oct. 27 1983			2b. HOUR 8:30 PM		
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR August 13, 1901	6. AGE (IN YEARS) LAST BIRTHDAY 82 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD Oct. 27, 1983	2d. HOUR 8:30 PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. CITY OR TOWN Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Louis Turk		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith B. Morgan		16. SOCIAL SECURITY NO. 216-46-3334				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-46-3334		17. INFORMANT ADDRESS Mrs. Marie L. Wallace, Friend, 6568 Claggett Ave., Dunkirk, Maryland 20754				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hematoma. 8880 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Skull Fracture. DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10 P.M. 10 9 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell in Park			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Park.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE UNKNOWN.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE John F. Tauber M.D.			TITLE (SPECIFY) M.D.			DATE SIGNED Oct. 31, 1983		
EXAMINER'S NAME (TYPE OR PRINT) John F. Tauber, M.D.			ADDRESS 8218 Wisconsin Avenue Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE October 31, 1983		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR NOV 4 1983		25b. REGISTRAR'S SIGNATURE John J. Carver		

(M)

RECEIVED

LIBRARY

(12)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) HANNA FONDROFF			2a. DATE OF DEATH MONTH DAY YEAR 10/15/83		2b. HOUR 2:40 P.M.	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH SEPTEMBER 4, 1876	6. AGE (IN YEARS LAST BIRTHDAY) 107		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) RUSSIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASHINGTON		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GROCER		12b. KIND OF BUSINESS OR INDUSTRY GROCERY	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN ROCKVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 6121 MONTROSE ROAD 20852	
14. FATHER'S NAME (UNASCERTAINABLE)			15. MOTHER'S MAIDEN NAME (UNASCERTAINABLE)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 579-66-6874		17. INFORMANT MELVYN COHEN, 14657 STONEWALL DRIVE, SILVER SPRING, MARYLAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTI-INFARCT DEMENTIA 4379 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRO-VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Many Yrs.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ADVANCED AGE						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10/15/83 to 10/15/83 , that (I) (we) lost saw the deceased alive on 10/15/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE D.D. Patel		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/15/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.D. PATEL		22e. ADDRESS 6121 MONTROSE RD, Rockville, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/17/1983		23c. NAME OF CEMETERY OR CREMATORY DISTRICT OF COLUMBIA		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D. C.
24. FUNERAL DIRECTOR DONALD N. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.				25a. DATE REC'D. BY REGISTRAR OCT 20 1983		25b. REGISTRAR'S SIGNATURE John J. Gault

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbonpaper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMM - 16 50M 4/82
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) LAURA FOSTER			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 11 1983		2b. HOUR 8:55 P.M.	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR APRIL 2 1930		
6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9a. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN ANNAPOLIS		
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		12b. KIND OF BUSINESS OR INDUSTRY SEAMSTRESS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 079-30-9288		17. INFORMANT ADDRESS ROBERT FOSTER, 437 EPPING WAY, ANNAPOLIS, MD 21401		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST 1830 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ADVANCED OVARIAN CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 8 , 19 83 , to OCTOBER 11 , 19 83 , that (I) (we) last saw the deceased alive on OCTOBER 11 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE B. K. Whalen, MD		DEGREE MD		22c. DATE SIGNED 13 OCT 83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. K. WHALEN, LCDR. MC, USNR		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND NATIONAL CAPITAL REGION, BETHESDA, MD 20814				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/15/83		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home		ADDRESS 12 Ridgely Ave Ann. Md. 21401		25a. DATE REC'D. BY REGISTRAR OCT 14 1983		
				25b. REGISTRAR'S SIGNATURE John J. Laniel		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Florence E. Fowler			2a. DATE OF DEATH MONTH DAY YEAR 10-19-83		2b. HOUR 12³⁵ P M		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 18, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Lady		12b. KIND OF BUSINESS OR INDUSTRY Joseph R. Harris	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY P.G.	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 2310 Amherst Road 20783		
14. FATHER'S NAME FIRST MIDDLE LAST Nathaniel Wilcox			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Wright				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 491-03-3306		17. INFORMANT Mrs. Mary F. Jones		ADDRESS Address Same as No. 13e.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 2859 IMMEDIATE CAUSE (a) CardioPulmonary arrest							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary Edema							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Anemia Upper G.I. Bleeding, Asthmatic Pericarditis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/11/83 19 to 10/19/83 19, that (I) (we) last saw the deceased alive on 10/18/83 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/19/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VIVEK C. VAID				22e. ADDRESS 7676 New Hampshire Ave Langley Park Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 21, 1983		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland				25a. DATE REC'D. BY REGISTRAR OCT. 24 1983			
				REGISTRAR'S SIGNATURE [Signature]			

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the attending physician must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) DONALD WILSON FYFE						2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 24 1983		2b. HOUR 2:11 PM	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH DAY MONTH YEAR NOVEMBER 23 1916		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEBRASKA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY USMC	
13a. STATE MARYLAND						13b. COUNTY PRINCE GEO'S		13c. CITY OR TOWN HYATTSVILLE	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM FYFE						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PEARL BRIAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 1934-1965		17. INFORMANT ADDRESS MARY F. FYFE, 5121 70th PLACE, HYATTSVILLE, MD 20784					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4349 IMMEDIATE CAUSE (a) MASSIVE CEREBRAL INFARCTIONS DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 10, 19 83, to OCTOBER 24, 19 83, that (I) (we) last saw the deceased alive on OCTOBER 24, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE L Hall, MC				DEGREE MP				22c. DATE SIGNED 20 Oct 83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. HALL, LT. MC, USNR				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/27/83		23c. NAME OF CEMETERY OR INTERMENT Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Ft Myer Arlington Va.			
24. FUNERAL DIRECTOR NAME Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Md.				25a. DATE REC'D. BY REGISTRAR OCT 27 1983		25b. REGISTRAR'S SIGNATURE J. J. Carver			

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1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

Journal of Interpersonal Violence 29(12)

Figure 1



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXPLAIN THE DELAY. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. HARRISON STREET, ANN ARBOR, MICHIGAN 48106.

BP.

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                                                                                            |        |                                                                                                           |                                   |                                                                                                                                                            |                                                                                             | 27682                                                                              |                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|-----------------------------------------------------------------------------------------------------------|-----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|----------------------------------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                 |        |                                                                                                           |                                   |                                                                                                                                                            |                                                                                             | REG. NO.                                                                           |                                  |
| 1- DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                     |        | FIRST                                                                                                     | MIDDLE                            | LAST                                                                                                                                                       | 20. DATE KNOWN OF DEATH ESTI-MATED                                                          |                                                                                    |                                  |
| Esperanza                                                                                                                                                                                                                                                                                                                                                                                                                               |        |                                                                                                           |                                   | Garcia                                                                                                                                                     | Oct 5 1983                                                                                  |                                                                                    |                                  |
| 3 SEX                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4 RACE | 5 DATE OF BIRTH<br>MONTH DAY YEAR                                                                         | 6 AGE (IN YEARS)<br>LAST BIRTHDAY | IF UNDER 1 YR.<br>MONTHS DAYS                                                                                                                              | IF UNDER 24 HRS.<br>HOURS MIN                                                               | 21. DATE PRONOUNCED DEAD                                                           |                                  |
| F                                                                                                                                                                                                                                                                                                                                                                                                                                       | W      | Sept. 30, 1886                                                                                            | 97 AS.                            |                                                                                                                                                            |                                                                                             | Oct 5 1983                                                                         |                                  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                |        | 7b CITIZEN OF WHAT COUNTRY?                                                                               |                                   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                             | 9 BALTIMORE CITY OR COUNTY OF DEATH                                                |                                  |
| Cuba                                                                                                                                                                                                                                                                                                                                                                                                                                    |        | Cuba                                                                                                      |                                   |                                                                                                                                                            |                                                                                             | Montgomery MD                                                                      |                                  |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                |        | 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                   |                                                                                                                                                            | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                                                                                    | 12b KIND OF BUSINESS OR INDUSTRY |
| Silver Spring                                                                                                                                                                                                                                                                                                                                                                                                                           |        | 1506 Overlook Dr.                                                                                         |                                   |                                                                                                                                                            | Housewife                                                                                   |                                                                                    | own home                         |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                              |        | 13a COUNTY                                                                                                |                                   | 13b CITY OR TOWN                                                                                                                                           | 13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                    |                                  |
| Md. Mont.                                                                                                                                                                                                                                                                                                                                                                                                                               |        | SS. Spg                                                                                                   |                                   | 1506 Overlook Dr.                                                                                                                                          |                                                                                             |                                                                                    |                                  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                   |        | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                              |                                   |                                                                                                                                                            |                                                                                             |                                                                                    |                                  |
| Jose Gomez                                                                                                                                                                                                                                                                                                                                                                                                                              |        | Adelaida Cepero                                                                                           |                                   |                                                                                                                                                            |                                                                                             |                                                                                    |                                  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF S. NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                                                                                                                                                       |        | 16b SOCIAL SECURITY NO.                                                                                   |                                   | 17 INFORMANT ADDRESS                                                                                                                                       |                                                                                             |                                                                                    |                                  |
| N/A                                                                                                                                                                                                                                                                                                                                                                                                                                     |        | 215-76-5111M                                                                                              |                                   | Manuel Boluda-Grandson- (same as 13e)                                                                                                                      |                                                                                             |                                                                                    |                                  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u><br><u>4291</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                                  |        |                                                                                                           |                                   |                                                                                                                                                            |                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                       |                                  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                     |        |                                                                                                           |                                   |                                                                                                                                                            |                                                                                             |                                                                                    |                                  |
| <u>None</u>                                                                                                                                                                                                                                                                                                                                                                                                                             |        |                                                                                                           |                                   |                                                                                                                                                            |                                                                                             |                                                                                    |                                  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |        | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                          |                                   |                                                                                                                                                            |                                                                                             | 20 AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  |
| <u>None</u>                                                                                                                                                                                                                                                                                                                                                                                                                             |        |                                                                                                           |                                   |                                                                                                                                                            |                                                                                             |                                                                                    |                                  |
| 21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                      |        | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                 |                                   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                                                                             |                                                                                    |                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                         |        |                                                                                                           |                                   |                                                                                                                                                            |                                                                                             |                                                                                    |                                  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                |        | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                |                                   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                             |                                                                                    |                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                         |        |                                                                                                           |                                   |                                                                                                                                                            |                                                                                             |                                                                                    |                                  |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |        |                                                                                                           |                                   |                                                                                                                                                            |                                                                                             |                                                                                    |                                  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                        |        | TITLE (SPECIFY)                                                                                           |                                   |                                                                                                                                                            |                                                                                             | DATE SIGNED                                                                        |                                  |
| <u>John S. Rogers</u>                                                                                                                                                                                                                                                                                                                                                                                                                   |        | M.D. Dep.                                                                                                 |                                   |                                                                                                                                                            |                                                                                             | Oct 5 1983                                                                         |                                  |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                         |        | ADDRESS                                                                                                   |                                   |                                                                                                                                                            |                                                                                             |                                                                                    |                                  |
| John S. Rogers, DME                                                                                                                                                                                                                                                                                                                                                                                                                     |        | 1919 Seminary Road, S.S. Md.                                                                              |                                   |                                                                                                                                                            |                                                                                             |                                                                                    |                                  |
| 23a BURIAL CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                 |        | 23b DATE                                                                                                  |                                   | 23c NAME OF CEMETERY OR CREMATORY                                                                                                                          |                                                                                             | 23d LOCATION<br>CITY OR TOWN COUNTY STATE                                          |                                  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                  |        | 10-7-1983                                                                                                 |                                   | Gate of Heaven Cemetery                                                                                                                                    |                                                                                             | Silver Spring Montgomery Md.                                                       |                                  |
| 24 FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                     |        | 25a DATE REC'D. BY REGISTRAR                                                                              |                                   | 25b REGISTRAR'S SIGNATURE                                                                                                                                  |                                                                                             |                                                                                    |                                  |
| Hines/Rinaldi Funeral Home                                                                                                                                                                                                                                                                                                                                                                                                              |        | OCT 11 1983                                                                                               |                                   | <u>John J. Lohrke</u>                                                                                                                                      |                                                                                             |                                                                                    |                                  |

Cuba

Cuba

Honolulu

own house

John

Conner

Abelard

Copero

W/A

W/A

212-76-2111

Manuel Heintz-Granston - (same as 122)

Manuel

12-7-1953

Date of Heaven Community Silver Spring Maryland, Md.

Winn/Winnid's Personal Home  
1100 N.E. Ave.,  
Silver Spring, Md.

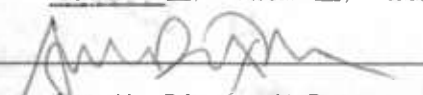

John S. Rogers, DMR

1219 Parkway Road, E.S. Md.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                       |  |                         |                                                                                                                                          |                                                                   |  |                                                                                                                                                          |                                                                                 |                                       |                                                                                                                     | 27683                                                                                         |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|---------------------------------------|---------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--|
| FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                         |                                                                                                                                          |                                                                   |  |                                                                                                                                                          |                                                                                 |                                       |                                                                                                                     | REG. NO.                                                                                      |  |
| 1. DECEASED NAME<br>[TYPE OR PRINT] <b>NANCY E. GINDER</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                         |                                                                                                                                          |                                                                   |  |                                                                                                                                                          |                                                                                 |                                       |                                                                                                                     | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10 11 19 83</b> |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br><b>white</b> |                                                                                                                                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Dec. 7, 1958</b>            |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. <b>24</b>                                                                                                        |                                                                                 | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. |                                                                                                                     | 7c. DATE PRONOUNCED DEAD <b>10 11 19 83 noon</b>                                              |  |
| 7a. BIRTHPLACE [STATE OR FOREIGN COUNTRY]<br><b>Wash. D.C.</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                            |                                                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                 |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                                                |                                                                                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>[IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS]<br><b>Holy Cross Hospital</b> |                                                                   |  |                                                                                                                                                          | 12a. USUAL OCCUPATION [TYPE OF WORK FOR MOST OF WORKING LIFE]<br><b>Student</b> |                                       |                                                                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>School</b>                                            |  |
| USUAL RESIDENCE [IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION]                                                                                                                                                                                                                                                                                                                                                                    |  |                         |                                                                                                                                          |                                                                   |  |                                                                                                                                                          |                                                                                 |                                       |                                                                                                                     |                                                                                               |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                         | 13b. COUNTY<br><b>Montgomery</b>                                                                                                         |                                                                   |  | 13c. CITY OR TOWN<br><b>Silver Spring</b>                                                                                                                |                                                                                 |                                       | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                        |                                                                                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel P. Ginder</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                         |                                                                                                                                          |                                                                   |  |                                                                                                                                                          |                                                                                 |                                       |                                                                                                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>C. J. Hirsch</b>                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>no</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                         |                                                                                                                                          | 16b. SOCIAL SECURITY NO.<br><b>213-48-1591</b>                    |  | 17. INFORMANT <b>Falls Church, Virginia 22043</b><br><b>John Gilchrist 2430 Claremont Drive</b>                                                          |                                                                                 |                                       |                                                                                                                     |                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bilateral pulmonary emboli</b><br>4151<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                                                                                      |  |                         |                                                                                                                                          |                                                                   |  |                                                                                                                                                          |                                                                                 |                                       |                                                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                           |  |                         |                                                                                                                                          |                                                                   |  |                                                                                                                                                          |                                                                                 |                                       |                                                                                                                     |                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                         |                                                                                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                 |  |                                                                                                                                                          |                                                                                 |                                       |                                                                                                                     | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                           |  |                         |                                                                                                                                          | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |                                                                                 |                                       |                                                                                                                     |                                                                                               |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                        |  |                         |                                                                                                                                          | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)       |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                        |                                                                                 |                                       |                                                                                                                     |                                                                                               |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |  |                         |                                                                                                                                          |                                                                   |  |                                                                                                                                                          |                                                                                 |                                       |                                                                                                                     |                                                                                               |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                           |  |                         |                                                                                                                                          |                                                                   |  | TITLE (SPECIFY)<br><b>Assistant</b> MEDICAL EXAMINER                                                                                                     |                                                                                 |                                       | DATE SIGNED <b>10-12-83</b>                                                                                         |                                                                                               |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                     |  |                         |                                                                                                                                          |                                                                   |  | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>                                                                                                           |                                                                                 |                                       |                                                                                                                     |                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  |                         | 23b. DATE<br><b>10/14/83</b>                                                                                                             |                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>                                                                                        |                                                                                 |                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland, Prince George, Md.</b>                                   |                                                                                               |  |
| 24. FUNERAL DIRECTOR<br><b>Tyson Wheeler Funeral Home, Inc.</b><br><b>1331 Rockville Pike Rockville, Md. 20852</b>                                                                                                                                                                                                                                                                                                                                            |  |                         |                                                                                                                                          |                                                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 19 1983</b>                                                                                                      |                                                                                 |                                       | 25b. REGISTRAR'S SIGNATURE<br> |                                                                                               |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

(VR A15 ME (5))  
20M 4/82STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                          |                                                                                                                                                    |                                                                                                                                                             |                                                                                                 |                                                                                                                                          |                                                                                     |                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>A Age Sigurdur Gotze</b>                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                          | 2a. DATE KNOWN OF DEATH<br>MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/><br><b>10-27-83</b> |                                                                                                                                                             |                                                                                                 | 2b. HOUR<br><b>10:01 AM</b>                                                                                                              |                                                                                     |                                                     |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/><br><b>Feb. 12, 1921</b>    | 6. AGE IN YEARS<br>(LAST BIRTHDAY)<br><b>62</b> YRS.                                                                                               | IF UNDER 1 YR.<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>                                                                             | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>                | 7c. DATE PRONOUNCED DEAD<br>MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/><br><b>10-27-83</b> |                                                                                     |                                                     |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Iceland</b>                                                                                                                                                                                                                                                                                                                                                                             |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Denmark</b>                                                                                           |                                                                                                                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                                                            |                                                                                     |                                                     |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>                                                                                                                                                                                                                                                                                                                                                                                          |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>454 College Parkway</b> |                                                                                                                                                    |                                                                                                                                                             |                                                                                                 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retailer</b>                                                         |                                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Imports</b> |
| 13a. STATE<br><b>Denmark</b>                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                          | 13b. COUNTY<br><b>3150</b>                                                                                                                         | 13c. CITY OR TOWN<br><b>Hellebaek</b>                                                                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>Boessemagergade 2</b> <b>99999</b>                                                                             |                                                                                     |                                                     |
| 14. FATHER'S NAME<br>FIRST <b>Hilbert</b> MIDDLE <b>Gotze</b> LAST <b>Gotze</b>                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                          |                                                                                                                                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ingibjorg</b> MIDDLE <b>Sigurdsdottir</b> LAST <b>Sigurdsdottir</b>                                                    |                                                                                                 |                                                                                                                                          |                                                                                     |                                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                          | 16b. SOCIAL SECURITY NO.<br><b>None</b>                                                                                                            |                                                                                                                                                             | 17. INFORMANT<br><b>Karen Ingvarsson</b> ADDRESS <b>454 College Pkwy Rockville, MD 20850</b>    |                                                                                                                                          |                                                                                     |                                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>9530</b> IMMEDIATE CAUSE (a) <b>Hanging</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                          |                         |                                                                                                                                          |                                                                                                                                                    |                                                                                                                                                             |                                                                                                 |                                                                                                                                          |                                                                                     |                                                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a.                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                          |                                                                                                                                                    |                                                                                                                                                             |                                                                                                 |                                                                                                                                          |                                                                                     |                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                  |                                                                                                                                                             |                                                                                                 |                                                                                                                                          | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                     |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                          | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                                  |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |                                                                                                                                          |                                                                                     |                                                     |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                          | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                        |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                                          |                                                                                     |                                                     |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |                                                                                                                                          |                                                                                                                                                    |                                                                                                                                                             |                                                                                                 |                                                                                                                                          |                                                                                     |                                                     |
| ACTUAL SIGNATURE <b>John Tauber</b>                                                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                          | TITLE (SPECIFY)                                                                                                                                    |                                                                                                                                                             |                                                                                                 | DATE SIGNED <b>10-27-83</b>                                                                                                              |                                                                                     |                                                     |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John Tauber</b>                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                          | ADDRESS <b>8218 Wisconsin Ave</b>                                                                                                                  |                                                                                                                                                             |                                                                                                 | MEDICAL EXAMINER                                                                                                                         |                                                                                     |                                                     |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                          | 23b. DATE<br><b>Oct. 29, 1983</b>                                                                                                                  |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crematory</b>                             |                                                                                                                                          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Alexandria, Virginia</b>           |                                                     |
| 24. FUNERAL DIRECTOR NAME<br><b>Robert A. Rumphrey Funeral Homes, P.A. Rockville, Maryland 20850</b>                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                          |                                                                                                                                                    |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 2 1983</b>                                              |                                                                                                                                          | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Smith</b>                                  |                                                     |

27684

11-12-1941  
11-12-1941



*[Faint, mostly illegible handwritten text, possibly a letter or report.]*

11-12-1941



*[Faint handwritten text at the bottom of the page, possibly a signature or date.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                               |                                                                                                                                      |                                                                                                                                                             |                                                                                   |                                                                                                 |                                                      |
|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <u>WILLIAM</u> MIDDLE <u>M</u> LAST <u>GOTTLIEB</u>              |                                                                                                                                      | 2a. DATE OF DEATH MONTH <u>10</u> DAY <u>20</u> YEAR <u>83</u>                                                                                              |                                                                                   | 2b. HOUR <u>1250</u> A.M.                                                                       |                                                      |
| 3. SEX<br><u>Male</u>                                                                                         | 4. RACE<br><u>WHITE</u>                                                                                                              | 5. DATE OF BIRTH<br>MONTH <u>6</u> DAY <u>04</u> YEAR <u>04</u>                                                                                             |                                                                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>19</u> YRS.                                               |                                                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>NEW YORK</u>                                                  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Montgomery</u> MD.                                   |                                                      |
| 10. CITY OR TOWN OF DEATH<br><u>Silver Spring</u>                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Holy Cross Hosp.</u> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>GROCER</u> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>MERCHANT</u> |
| 13a. STATE<br><u>MARYLAND</u>                                                                                 |                                                                                                                                      | 13b. COUNTY<br><u>MONTGOMERY</u>                                                                                                                            | 13c. CITY OR TOWN<br><u>SILVER SPRING</u>                                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                      |
| 14. FATHER'S NAME<br>FIRST <u>AARON</u> MIDDLE <u>GOTTLIEB</u>                                                |                                                                                                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>SARAH</u> MIDDLE <u>CHADICK</u>                                                                                        |                                                                                   |                                                                                                 |                                                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><u>NO</u> |                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br><u>577-34-8317A</u>                                                                                                             |                                                                                   | 17. INFORMANT<br><u>BESS GOTTLIEB, 8600 16th STREET, SILVER SPRING, MARYLAND</u>                |                                                      |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

5715

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Bilateral cerebral (parietal lobe) infarct

|                                                                                                                                                                                                                                                                                                                                                        |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                          |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                                                            |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>10/19</u> 19 <u>83</u> to <u>10-20</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>10/19</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>Jason Greiger M.D.</u>                                                                                                                                                                                                                                                                                                            |  | DEGREE                                                                 |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>10-20-83</u>                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>JASON GREIGER, M.D.</u>                                                                                                                                                                                                                                                                                    |  | 22e. ADDRESS<br><u>8830 CAMERON STREET, SILVER SPRING, MD. 20910</u>   |  |                                                                                                                                            |  |                                                                                                                            |  |

|                                                                                                            |                                |                                                                      |                                                      |
|------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------|------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br><u>BURIAL</u>                                                           | 23b. DATE<br><u>10/21/1983</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>JUDEAN MEMORIAL GARDENS</u> | 23d. LOCATION<br><u>DINEY, MONTGOMERY, MARYLAND</u>  |
| 24. DONALD M. OR STEIN HEBREW MEMORIAL FUNERAL HOME<br><u>232 CARROLL STREET, N. W., WASHINGTON, D. C.</u> |                                | 25a. DATE REC'D. BY REGISTRAR<br><u>OCT 24 1983</u>                  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Greiner</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



|                                    |  |                                     |  |
|------------------------------------|--|-------------------------------------|--|
| 1. AGENCY USE ONLY (Leave blank)   |  | 2. GSA FPMR (41 CFR) 101-11.6       |  |
| 3. DATE OF REPORT                  |  | 4. REPORT NUMBER                    |  |
| 5. AUTHOR                          |  | 6. PERFORMING ORGANIZATION NAME     |  |
| 7. PERFORMING ORGANIZATION ADDRESS |  | 8. PERFORMING ORGANIZATION CITY     |  |
| 9. PERFORMING ORGANIZATION STATE   |  | 10. PERFORMING ORGANIZATION ZIP     |  |
| 11. PERFORMING ORGANIZATION PHONE  |  | 12. PERFORMING ORGANIZATION FAX     |  |
| 13. PERFORMING ORGANIZATION E-MAIL |  | 14. PERFORMING ORGANIZATION WWW     |  |
| 15. PERFORMING ORGANIZATION URL    |  | 16. PERFORMING ORGANIZATION E-MAIL  |  |
| 17. PERFORMING ORGANIZATION WWW    |  | 18. PERFORMING ORGANIZATION E-MAIL  |  |
| 19. PERFORMING ORGANIZATION WWW    |  | 20. PERFORMING ORGANIZATION E-MAIL  |  |
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| 93. PERFORMING ORGANIZATION WWW    |  | 94. PERFORMING ORGANIZATION E-MAIL  |  |
| 95. PERFORMING ORGANIZATION WWW    |  | 96. PERFORMING ORGANIZATION E-MAIL  |  |
| 97. PERFORMING ORGANIZATION WWW    |  | 98. PERFORMING ORGANIZATION E-MAIL  |  |
| 99. PERFORMING ORGANIZATION WWW    |  | 100. PERFORMING ORGANIZATION E-MAIL |  |



U.S. GENERAL ACCOUNTING OFFICE  
WASHINGTON, D.C. 20548  
1-800-424-9090  
WWW.GAO.GOV

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                            |  |                                                                                                                                          |  | REG. NO.                                                                                                                                                      |  |                                                                                                                         |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                          |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                              |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ROSE ELIZABETH GOUCHER</b>                                                                                                                                                                                                                                                                                             |  |                                                                                                                                          |  | 2b. HOUR<br><b>10:50pm</b>                                                                                                                                    |  |                                                                                                                         |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br><b>CAUCASIAN</b>                                                                                                              |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>JUNE 27 1889</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>94</b>                                                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NAVAL HOSPITAL BETHESDA</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                                                                             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>                                                                        |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY<br><b>MONTGOMERY</b>                                                                                                         |  | 13c. CITY OR TOWN<br><b>BETHESDA</b>                                                                                                                          |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>CHARLES J. HANLON</b>                                                                                                                                                                                                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>JANE LALLY</b>                                                                          |  | 13e. STREET ADDRESS<br><b>4956 SENTINEL DR. 20816</b>                                                                                                         |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br><b>557-40-1693</b>                                                                                           |  | 17. INFORMANT ADDRESS<br><b>MARION SLATTERY 4956 SENTINEL DR. BETHESDA</b>                                                                                    |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br><b>4280</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MD. 20816</b>                                                                                              |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____                                                                                                                                                                                                                                       |  |                                                                                                                                          |  |                                                                                                                                                               |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                             |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)                                                                                |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 5, 19 1983</b> , to <b>OCTOBER 7, 19 83</b> , that (I) (we) last saw the deceased alive on <b>OCTOBER 7, 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                     |  |                                                                                                                                          |  |                                                                                                                                                               |  |                                                                                                                         |  |
| 22b. SIGNATURE OF PHYSICIAN<br><b>Michael D. Canty</b>                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                          |  | DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>8 Oct 83</b>                                                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MICHAEL D. CANTY, LT, MC, USNR</b>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                          |  | 22e. ADDRESS<br><b>NAVAL HOSPITAL BETHESDA MD, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION 20816</b>                                                       |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>Oct. 12, 1983</b>                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cem.</b>                                                                                          |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Arlington, Virginia</b>                                                   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>James D. DeVol</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                          |  | 24b. ADDRESS<br><b>DeVol Funeral Home Washington, D.C.</b>                                                                                                    |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1983</b>                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                                                                                           |  |                                                                                                                         |  |

BP \_\_\_\_\_

THE UNIVERSITY OF CHICAGO  
LIBRARY  
1000 S. MICHIGAN AVE.  
CHICAGO, ILL. 60607



11-11-82

Oct. 12, 1982  
David Turner  
Washington, D.C.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                   |                                                                                                                                                 |                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PAUL P GRALNICK</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 17 83</b>                                                                                                                                                                                                                                                                                                         |                                                                                                                   | 2b. HOUR<br><b>6 30 P M</b>                                                                                                                     |                                                                 |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4. RACE<br><b>CAUCASEAN</b>                                                                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 7 16</b>                                                                                                                                                                                                                                                                                                            |                                                                                                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                                                                                               |                                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                             | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                    |                                                                                                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD                                                                                    |                                                                 |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |                                                                                                                                                                                                                                                                                                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>U.S. Patent &amp; Trademark Government</b> |                                                                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                               |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                         | 13b. COUNTY<br><b>MONTGOMERY</b>                                                                                                                                                                                                                                                                                                                               | 13c. CITY OR TOWN<br><b>LYTTONSVILLE</b>                                                                          | 13d. STREET ADDRESS<br><b>2445 Lyttonsville Rd</b>                                                                                              |                                                                 |
| 14. FATHER'S NAME<br><b>Harry</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br><b>Molly</b>                                                                                                                                                                                                                                                                                                                       |                                                                                                                   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>UNKNOWN</b>                                                           |                                                                 |
| 17. SOCIAL SECURITY NO.<br><b>WW 11</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                         | 18. INFORMANT<br><b>Mina Gralnick</b>                                                                                                                                                                                                                                                                                                                          |                                                                                                                   | 19. ADDRESS<br><b>same as #13</b>                                                                                                               |                                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CANCER OF THE PANCREAS</b><br>1579 DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. |                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                   |                                                                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 MONTHS</b> |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                               |                                                                                                                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                            |                                                                 |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                         | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                          |                                                                                                                   |                                                                                                                                                 |                                                                 |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                                                                                 |                                                                                                                   |                                                                                                                                                 |                                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                                         |                                                                                                                   |                                                                                                                                                 |                                                                 |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                         | 22a. I certify that (1) (this hospital) attended the deceased from <b>MARCH</b> 19 <b>83</b> , to <b>OCT 17</b> 19 <b>83</b> , that (1) (we) last saw the deceased alive on <b>OCT 16</b> 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. |                                                                                                                   |                                                                                                                                                 |                                                                 |
| 22b. SIGNATURE<br><b>Margaret A. Voith MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                         | DEGREE                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                   | 22c. DATE SIGNED                                                                                                                                |                                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARGARET A. VOITH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                         | 22e. ADDRESS<br><b>106 IRVING ST NW SUITE #21 WASHINGTON, DC 20010</b>                                                                                                                                                                                                                                                                                         |                                                                                                                   | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                         | 23b. DATE<br><b>10-19-83</b>                                                                                                                                                                                                                                                                                                                                   |                                                                                                                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King David Cemetery</b>                                                                                |                                                                 |
| 23d. LOCATION<br><b>Falls Church, Va</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                         | 23e. COUNTY<br><b>VA</b>                                                                                                                                                                                                                                                                                                                                       |                                                                                                                   | 23f. STATE<br><b>VA</b>                                                                                                                         |                                                                 |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ives-Pearson Funeral Home</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                         | 24b. ADDRESS<br><b>F.C., VA. 22046</b>                                                                                                                                                                                                                                                                                                                         |                                                                                                                   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 21 1983</b>                                                                                             |                                                                 |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                   |                                                                                                                                                 |                                                                 |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified aforesaid.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 should be retained by the hospital or attending physician.

BP



1-7-07-0153

20% COTTON

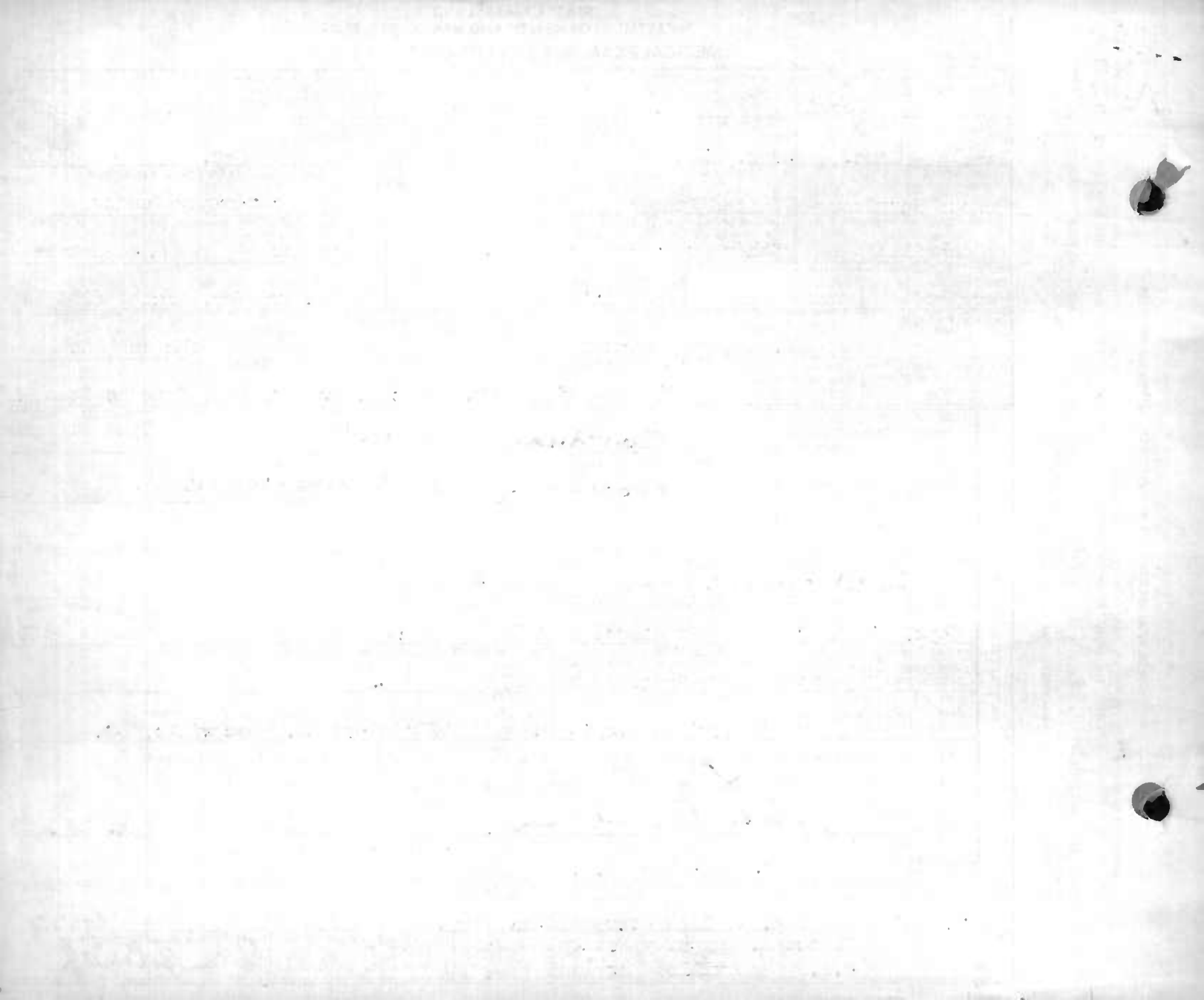


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                     |  |                                  |  |                                                                                                                                                     |  |                                                                                                                                                        |  |                                                                                                                                                             |                                                                     | REG. NO.                                                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Jessie S. Granum</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                  |  |                                                                                                                                                     |  | 2a. DATE KNOWN OF DEATH<br><input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR<br><b>Oct. 1, 1983</b> |  |                                                                                                                                                             |                                                                     | 2b. HOUR<br><b>5:20 PM</b>                                            |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>Cauc.</b>          |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 13, 1889</b>                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>94 YRS.</b>                                                                                                      |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN                                                                                                                     |                                                                     | 2c. DATE PRONOUNCED DEAD<br><b>Oct. 1, 1983</b>                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Dakota Territory</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                                |  |                                                                                                                                                        |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD.</b> |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>                                                                                                                                                                                                                                                                                                                                                                                               |  |                                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Shady Grove Adventist Hospital</b> |  |                                                                                                                                                        |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Broker</b>                                                                              |                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Realestate</b>                |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                  |  |                                  |  |                                                                                                                                                     |  |                                                                                                                                                        |  |                                                                                                                                                             |                                                                     |                                                                       |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY<br><b>Montgomery</b> |  | 13c. CITY OR TOWN<br><b>Rockville</b>                                                                                                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                        |  | 13e. STREET ADDRESS<br><b>22 Orchard Way, North (20854)</b>                                                                                                 |                                                                     |                                                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James S. Soutar</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                                  |  |                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eva McLaughlin</b>                                                                                 |  |                                                                                                                                                             |                                                                     |                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                                                              |  |                                  |  | 16b. SOCIAL SECURITY NO.<br><b>374-34-6450A</b>                                                                                                     |  | 17. INFORMANT ADDRESS<br><b>Mr. James O. Granum, Son, Same as item #13</b>                                                                             |  |                                                                                                                                                             |                                                                     |                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4140</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>Coronary arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                  |  |                                                                                                                                                     |  |                                                                                                                                                        |  |                                                                                                                                                             |                                                                     |                                                                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Gastrointestinal Bleeding</b>                                                                                                                                                                                                                                                                     |  |                                  |  |                                                                                                                                                     |  |                                                                                                                                                        |  |                                                                                                                                                             |                                                                     |                                                                       |  |
| 19a. DATE OF OPERATION<br><b>Sept. 27, 1983</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>Fractured Left Hip</b>                                                                      |  |                                                                                                                                                        |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                         |                                                                     |                                                                       |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                           |  |                                  |  | 21b. TIME OF INJURY<br>HOUR AM MONTH DAY YEAR<br><b>4:00 P.M. Sept. 25 19 83</b>                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Fell</b>                                                           |  |                                                                                                                                                             |                                                                     |                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                     |  |                                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Rockville Nursing Home</b>                                                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>303 Adclare Rd., Rockville, MD.</b>                                                            |  |                                                                                                                                                             |                                                                     |                                                                       |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                 |  |                                  |  |                                                                                                                                                     |  |                                                                                                                                                        |  |                                                                                                                                                             |                                                                     |                                                                       |  |
| ACTUAL SIGNATURE<br><b>John Tauber</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                  |  |                                                                                                                                                     |  | TITLE (SPECIFY)<br><b>M.D.</b>                                                                                                                         |  |                                                                                                                                                             | MEDICAL EXAMINER<br><b>8218 Wisconsin Avenue Bethesda, Maryland</b> |                                                                       |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>John Tauber, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                  |  |                                                                                                                                                     |  | DATE SIGNED<br><b>Oct. 2, 1983</b>                                                                                                                     |  |                                                                                                                                                             |                                                                     |                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                                  |  | 23b. DATE<br><b>Oct. 2, 1983</b>                                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crematory Alexandria Virginia</b>                                                                |  |                                                                                                                                                             |                                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland</b>                                                                                                                                                                                                                                                                                                                                          |  |                                  |  |                                                                                                                                                     |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 5 1983</b>                                                                                                     |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Grier</b>                                                                                                          |                                                                     |                                                                       |  |

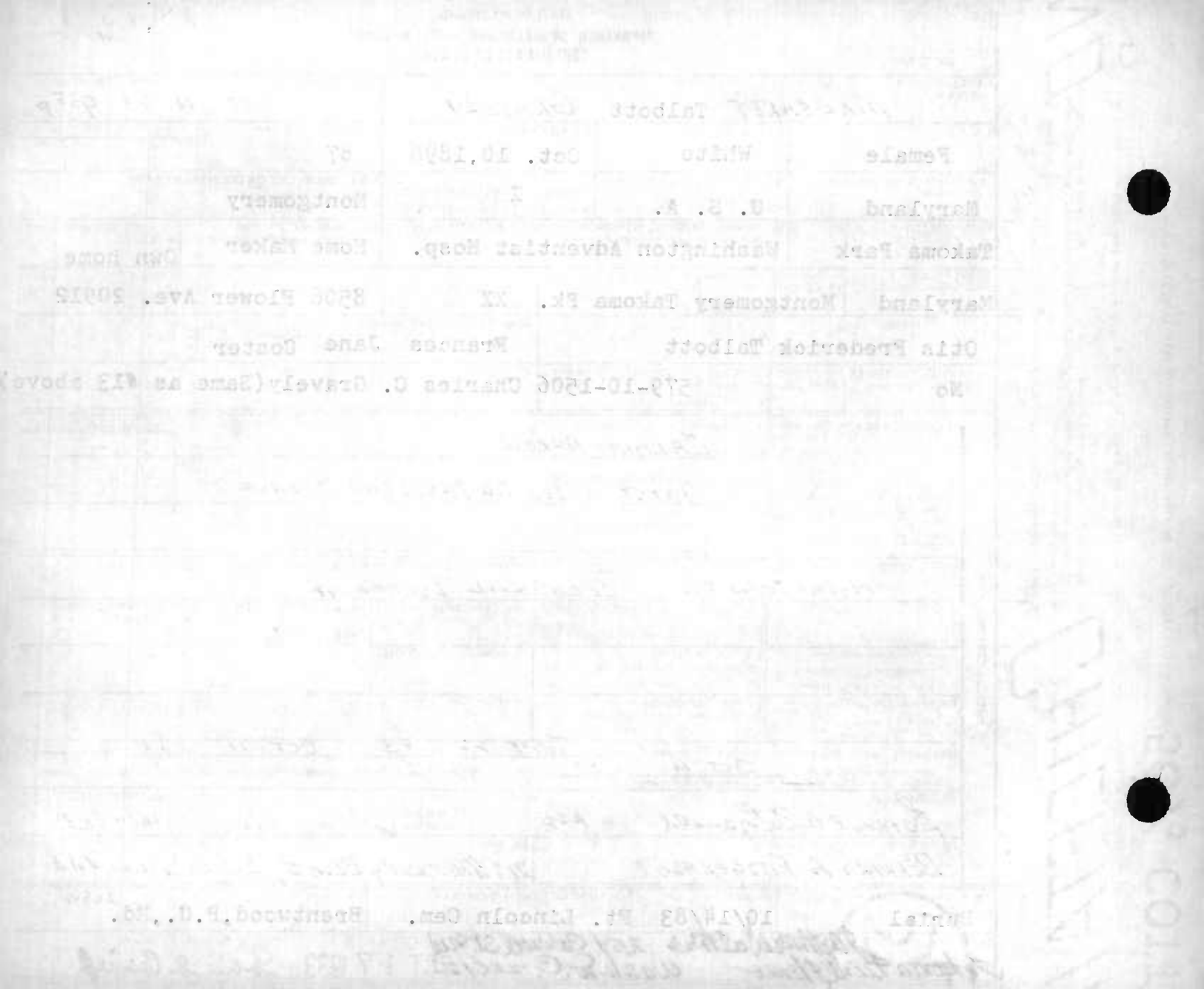




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 4/82  
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                           |  |                                                                                                 |  | REG. NO.                                                                                                                   |  |                                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARGARET Talbott GRAVELY</b>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                |  | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>11</b> YEAR <b>83</b>                                                                                              |  |                                                                                                 |  | 2b. HOUR<br><b>935 P.M.</b>                                                                                                |  |                                              |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><b>White</b>                                                                                                                        |  | 5. DATE OF BIRTH<br>MONTH <b>Oct.</b> DAY <b>10</b> YEAR <b>1896</b>                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b>                                                    |  | IF UNDER 1 YEAR<br>MONTHS <b>YRS.</b>                                                                                      |  | IF UNDER 24 HRS.<br>HOURS <b>MIN.</b>        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD                                    |  |                                                                                                                            |  |                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hosp.</b> |  |                                                                                                                                                                |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home Maker</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>                                                                       |  |                                              |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 13b. COUNTY<br><b>Montgomery</b>                                                                                                               |  | 13c. CITY OR TOWN<br><b>Takoma Pk.</b>                                                                                                                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>8508 Flower Ave. 20912</b>                                                                       |  |                                              |  |
| 14. FATHER'S NAME<br>FIRST <b>Otis Frederick</b> MIDDLE <b>Talbott</b> LAST                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Frances</b> MIDDLE <b>Jane</b> LAST <b>Coster</b>                                                                         |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>579-10-1506</b>                                                                  |  | 17. INFORMANT<br>ADDRESS<br><b>Charles C. Gravelly (Same as #13 above)</b>                                                                                     |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>ARTERIOSCLEROTIC VASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                                                |  |                                                                                                                                                                |  |                                                                                                 |  |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>HYPERTENSION; CEREBRAL ISCHEMIA</b>                                                                                                                                                                                                                          |  |                                                                                                                                                |  |                                                                                                                                                                |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                               |  |                                                                                                                                                                |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                 |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT 22</b> 19 <b>83</b> , to <b>OCT 11</b> 19 <b>83</b> , that (I) <del>was</del> lost<br>saw the deceased alive on <b>OCT 11</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) <del>did not</del> view the body after death.            |  |                                                                                                                                                |  |                                                                                                                                                                |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |
| 22b. SIGNATURE<br><b>Bernard A. Fitzgerald</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                |  | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>10/11/83</b>                                                                                        |  |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BERNARD A. FITZGERALD</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                |  | 22e. ADDRESS<br><b>217 UNIVERSITY BLVD E, SILVER SPRING MD</b>                                                                                                 |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br><b>10/14/83</b>                                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cem.</b>                                                                                                  |  |                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN <b>Brentwood, P.G., Md.</b> COUNTY <b>20941</b> STATE                                        |  |                                              |  |
| 24. FUNERAL DIRECTOR<br>P NAME <b>William Walters</b> ADDRESS <b>254 Carroll St. N.W.</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                |  | 24a. DATE REC'D. BY REGISTRAR<br><b>OCT 17 1983</b>                                                                                                            |  |                                                                                                 |  | 24b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                                                        |  |                                              |  |



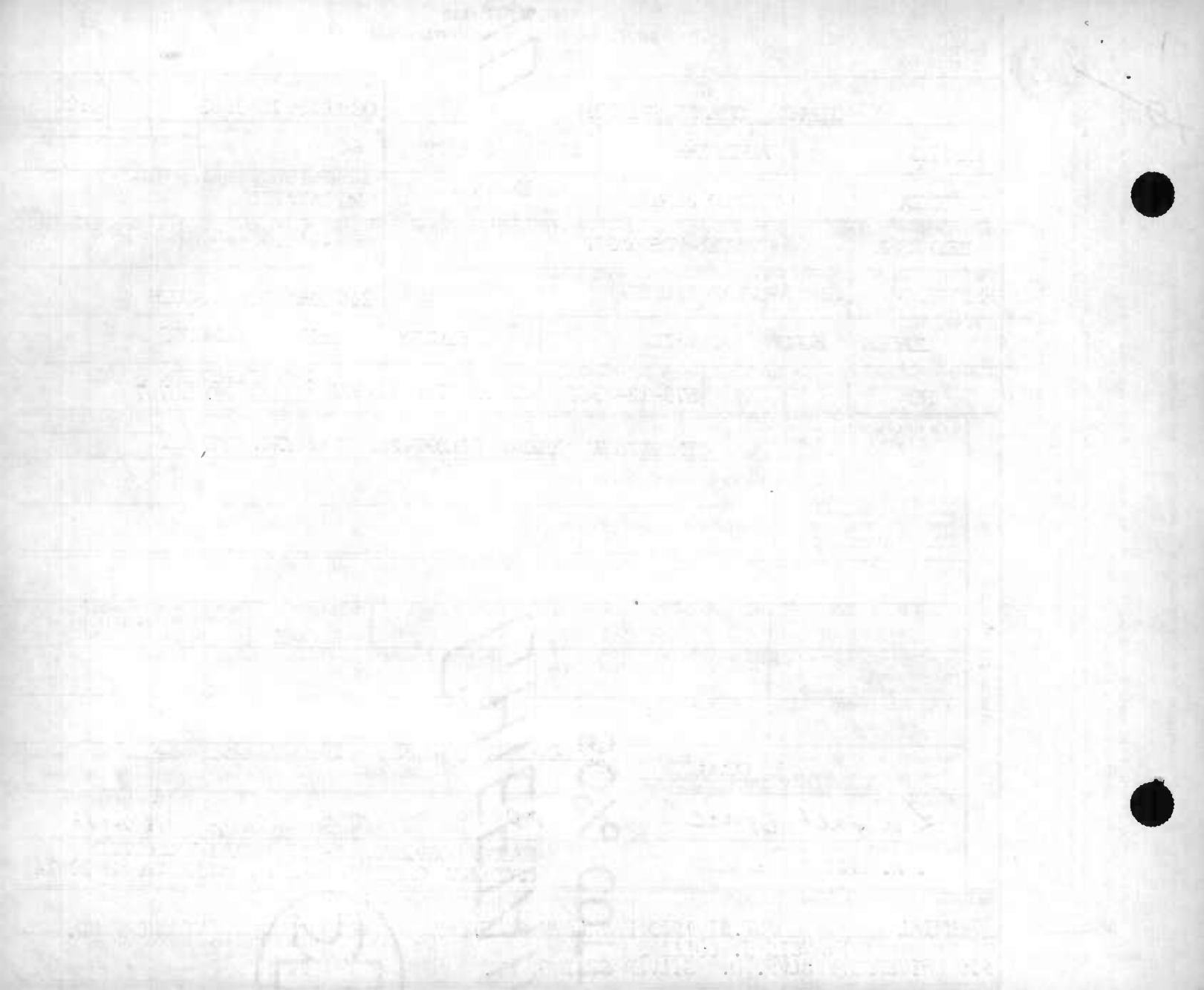
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                       |  |                                                                                                            |  | REG. NO.                                                                                                                                                          |  |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MILDRED ODESSA GRIFFIN</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                            |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>OCTOBER 18 1983</b>                                                                                                        |  | 2b. HOUR<br><b>4:00 P.M.</b>                                                                                               |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br><b>CAUCASIAN</b>                                                                                |  | 5. DATE OF BIRTH<br><b>FEBRUARY 5 1919</b>                                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b>                                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>VIRGINIA</b>                                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>                                                       |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN A FALLOUT SHELTER)<br><b>NAVAL HOSPITAL</b> |  | 12a. USUAL OCCUPATION (IF NOT FULLY WORKING LIFE)<br><b>HOUSEWIFE</b>                                                                                             |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>FIRST MIDDLE LAST<br><b>MARYLAND ANNE ARUNDEL LAUREL TOWN</b>                                                                                                                                                                                                                              |  |                                                                                                            |  | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                   |  | 13c. STREET ADDRESS<br><b>246 IRONSHIRE SOUTH 20707</b>                                                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CLAUDE BULON ASHWELL</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                            |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SICILY ANN SCRUGGS</b>                                                                                        |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.<br><b>579-12-4366</b>                                                             |  | 17. INFORMANT<br><b>WILLIE LEE GRIFFIN</b> ADDRESS<br><b>246 IRONSHIRE SOUTH LAUREL MD 20707</b>                                                                  |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1991 METASTATIC ADENO CARCINOMA OF UNKNOWN PRIMARY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                                                            |  |                                                                                                                                                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a                                                                                                                                                                                                                                                         |  |                                                                                                            |  |                                                                                                                                                                   |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                           |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                              |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                    |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>13 OCTOBER 1983</b> to <b>18 OCTOBER 1983</b> , that (I) (we) lost saw the deceased alive on <b>18 OCTOBER 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |  |                                                                                                            |  |                                                                                                                                                                   |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>L. W. Hall Lt MC USNR</b>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                            |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>18 Oct 83</b>                                                                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>L. W. HALL LT MC USNR</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                            |  | 22e. ADDRESS<br><b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND<br/>NATIONAL CAPITAL REGION, BETHESDA MD 20814</b>                                                       |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                 |  | 23b. DATE<br><b>OCT. 21, 1983</b>                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKLAWN CEMETERY</b>                                                                                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROCKVILLE MONTGOMERY MD.</b>                                              |  |
| 24. FUNERAL DIRECTOR<br><b>FRANCIS J. COLLINS</b><br><b>500 UNIVERSITY BLVD., W. SILVER SPRING, MD.</b>                                                                                                                                                                                                                                                                                    |  |                                                                                                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 27 1983</b>                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                                                        |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be returned to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified above.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                               |  | REG. NO.                                                                                                                                                    |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EDITH N. GRILL</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                               |  | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>30</b> YEAR <b>83</b>                                                                                           |  |                                                                                                                            |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>White</b>                                                                                                                       |  | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>17</b> YEAR <b>04</b>                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.                                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>HONTBOMERY</b> MD.                                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Gaithersburg</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>WILSON HEALTH CARE CENTER</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                                                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>                                                                            |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                               |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST <b>William</b> MIDDLE <b>H.</b> LAST <b>Grill</b>                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Minnie</b> MIDDLE <b>Otto</b> LAST <b>Otto</b>                                                                         |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.<br><b>218-36-3250</b>                                                                                                |  | 17. INFORMANT<br>ADDRESS<br><b>Gordon Flautt 1236 Circle Drive 21227</b>                                                                                    |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic breast adenocarcinoma</b> 4 years<br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b> |  |                                                                                                                                               |  |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                               |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                              |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 10, 1980</b> to <b>Oct 30, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                       |  |                                                                                                                                               |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 23a. SIGNATURE<br><b>James R. Moore Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                               |  | DEGREE<br><b>MD</b>                                                                                                                                         |  | 22c. DATE SIGNED<br><b>10-31-83</b>                                                                                        |  |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                               |  | 22e. ADDRESS<br><b>207 Brooks Ave Gaithersburg Md</b>                                                                                                       |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br><b>11/3/83</b>                                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>                                                                                           |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b>Md</b>                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.</b>                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                               |  | ADDRESS<br><b>4107 Wilkens Ave.</b>                                                                                                                         |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 2 1983</b>                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE<br><b>James E. Carver</b>                                                                                                        |  |                                                                                                                            |  |

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20% COTTON

CHIEFMAN





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                           |                                                                        |                                                                                                                                                             |                                                            |                                                                                |                                                                     |                                            |                                                                |                             |      |                                                                  |          |                                   |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------|----------------------------------------------------------------|-----------------------------|------|------------------------------------------------------------------|----------|-----------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                |  | REG. NO.                                                                                                  |                                                                        |                                                                                                                                                             |                                                            |                                                                                |                                                                     |                                            |                                                                |                             |      |                                                                  |          |                                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                           |                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH                                          |                                                                                | MONTH                                                               |                                            | DAY                                                            |                             | YEAR |                                                                  | 2b. HOUR |                                   |  |
| Charles E. GROGG, Sr.                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                           |                                                                        |                                                                                                                                                             | 10.                                                        |                                                                                | 5.83                                                                |                                            | 11:05                                                          |                             | A    |                                                                  | M        |                                   |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE                                                                                                   |                                                                        | 5. DATE OF BIRTH                                                                                                                                            |                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)                                                |                                                                     | IF UNDER 1 YEAR                            |                                                                | IF UNDER 24 HRS.            |      |                                                                  |          |                                   |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | Caucasian                                                                                                 |                                                                        | 9 MONTH 5 DAY 13 YEAR                                                                                                                                       |                                                            | 70 YRS.                                                                        |                                                                     | MONTHS                                     |                                                                | DAYS                        |      | HOURS                                                            |          | MIN.                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH                                           |                                                                     |                                            |                                                                |                             |      |                                                                  |          |                                   |  |
| Virginia                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | United States                                                                                             |                                                                        |                                                                                                                                                             |                                                            | Montgomery County MD.                                                          |                                                                     |                                            |                                                                |                             |      |                                                                  |          |                                   |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                        |                                                                                                                                                             |                                                            |                                                                                |                                                                     |                                            |                                                                |                             |      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |          | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Rockville                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | Shady Grove Adventist Hosp.                                                                               |                                                                        |                                                                                                                                                             |                                                            |                                                                                |                                                                     |                                            |                                                                |                             |      | Labor Foreman                                                    |          | Construction                      |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                           |                                                                        |                                                                                                                                                             |                                                            |                                                                                |                                                                     |                                            |                                                                |                             |      |                                                                  |          |                                   |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY                                                                                               |                                                                        | 13c. CITY OR TOWN                                                                                                                                           |                                                            | 13d. INSIDE CITY LIMITS?                                                       |                                                                     | 13e. STREET ADDRESS                        |                                                                |                             |      |                                                                  |          |                                   |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | Montgomery                                                                                                |                                                                        | Rockville                                                                                                                                                   |                                                            | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                                                     | 308 Crabb Avenue (20850)                   |                                                                |                             |      |                                                                  |          |                                   |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                           |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME                                   |                                                                                |                                                                     |                                            |                                                                |                             |      |                                                                  |          |                                   |  |
| Thomas Henry Grogg                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                           |                                                                        |                                                                                                                                                             | Ireland Keese                                              |                                                                                |                                                                     |                                            |                                                                |                             |      |                                                                  |          |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                           |                                                                        |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)    |                                                                                | 17. INFORMANT ADDRESS                                               |                                            |                                                                |                             |      |                                                                  |          |                                   |  |
| Yes                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                           |                                                                        |                                                                                                                                                             | WW II                                                      |                                                                                | 213-12-3334 Mary F. Grogg, same as #13                              |                                            |                                                                |                             |      |                                                                  |          |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>GASTROINTESTINAL HEMORRHAGE</u><br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ANTICOAGULATION FOR CEREBROVASCULAR ACCIDENT.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>STATUS POST MULTIPLE STROKES.</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 WEEK.<br>2 MONTHS.<br>6 MONTHS. |  |                                                                                                           |                                                                        |                                                                                                                                                             |                                                            |                                                                                |                                                                     |                                            |                                                                |                             |      |                                                                  |          |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                         |  |                                                                                                           |                                                                        |                                                                                                                                                             |                                                            |                                                                                |                                                                     |                                            |                                                                |                             |      |                                                                  |          |                                   |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                            |                                                                                | 20a. AUTOPSY?                                                       |                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                             |      |                                                                  |          |                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |                                                                        |                                                                                                                                                             |                                                            |                                                                                | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                            | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                             |      |                                                                  |          |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                    |  |                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                                                     |                                            |                                                                |                             |      |                                                                  |          |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                |  |                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                     |                                            |                                                                |                             |      |                                                                  |          |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 6, 1983</u> to <u>10.5, 1983</u> , that (I) (we) lost<br>saw the deceased alive on <u>10/5/83</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                                     |  |                                                                                                           |                                                                        |                                                                                                                                                             |                                                            |                                                                                |                                                                     |                                            |                                                                |                             |      |                                                                  |          |                                   |  |
| 22b. SIGNATURE<br><u>E. P. Flannery</u>                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                           |                                                                        |                                                                                                                                                             | DEGREE<br>MD                                               |                                                                                |                                                                     |                                            |                                                                | 22c. DATE SIGNED<br>10/5/83 |      |                                                                  |          |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>EUGENE P. FLANNERY, M.D.                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                           |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br>18111 Prince Philip Drive OLNEY, Md. 20832 |                                                                                |                                                                     |                                            |                                                                |                             |      |                                                                  |          |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                           | 23b. DATE                                                              |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY                         |                                                                                |                                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |                                                                |                             |      |                                                                  |          |                                   |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                           | Oct. 8, 1983                                                           |                                                                                                                                                             | Parklawn Mem. Park                                         |                                                                                |                                                                     | Rockville, Maryland                        |                                                                |                             |      |                                                                  |          |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                           |                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR                              |                                                                                |                                                                     |                                            |                                                                | 25b. REGISTRAR'S SIGNATURE  |      |                                                                  |          |                                   |  |
| Robert A. Pumphrey Funeral<br>Homes, P.A. Rockville, Maryland 20850                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                           |                                                                        |                                                                                                                                                             | OCT 11 1983                                                |                                                                                |                                                                     |                                            |                                                                | <u>John J. Connelley</u>    |      |                                                                  |          |                                   |  |

BP



10:00



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10:00

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                             |                                                                        |                                                                 |                                     |                                                                                |                                  |                                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------|--------------------------------------------------------------------------------|----------------------------------|---------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             | 2a. DATE OF DEATH                                                      |                                                                 |                                     | 2b. HOUR                                                                       |                                  |                                                                     |
| Lorne M. Guinan                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                             | October 17, 1983                                                       |                                                                 |                                     | 8:00P M                                                                        |                                  |                                                                     |
| 3 SEX                                                                                                                                                                                                                                                                                                                                                                | 4 RACE                                                                                                    | 5. DATE OF BIRTH                                                                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)                                        |                                                                 |                                     | IF UNDER 1 YEAR                                                                |                                  |                                                                     |
| Male                                                                                                                                                                                                                                                                                                                                                                 | Caucasian                                                                                                 | October 11, 1906                                                                                                                                            | 77 YRS.                                                                |                                                                 |                                     | MONTHS DAYS HOURS MIN.                                                         |                                  |                                                                     |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                             | 7b CITIZEN OF WHAT COUNTRY?                                                                               | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                        |                                                                 | 9 BALTIMORE CITY OR COUNTY OF DEATH |                                                                                |                                  |                                                                     |
| Nebraska                                                                                                                                                                                                                                                                                                                                                             | United States                                                                                             |                                                                                                                                                             |                                                                        |                                                                 | Montgomery County, MD.              |                                                                                |                                  |                                                                     |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                             |                                                                        | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                     |                                                                                | 12b KIND OF BUSINESS OR INDUSTRY |                                                                     |
| Silver Spring                                                                                                                                                                                                                                                                                                                                                        | Holy Cross Hospital                                                                                       |                                                                                                                                                             |                                                                        | Consultant                                                      |                                     |                                                                                | Public Administration Service    |                                                                     |
| 13a STATE                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                             | 13b CITY OR TOWN                                                       |                                                                 |                                     | 13c STREET ADDRESS                                                             |                                  |                                                                     |
| Maryland                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           |                                                                                                                                                             | Montgomery                                                             |                                                                 |                                     | 14541 Kelmscot Drive                                                           |                                  |                                                                     |
| 14 FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME                                               |                                                                 |                                     | Zip: 20906                                                                     |                                  |                                                                     |
| Ed Guinan                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                             | Celia Leaden                                                           |                                                                 |                                     |                                                                                |                                  |                                                                     |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             | 16b SOCIAL SECURITY NO.                                                |                                                                 |                                     | 17. INFORMANT                                                                  |                                  |                                                                     |
| Yes                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             | WWII                                                                   |                                                                 |                                     | 14541 Kelmscot Dr, Silver Spring, MD                                           |                                  |                                                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY.                                                                                                                                                                                                                                                             |                                                                                                           |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                           |                                                                 |                                     |                                                                                |                                  |                                                                     |
| IMMEDIATE CAUSE (a) <u>Pulmonary infarction</u>                                                                                                                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                             | 2 hrs                                                                  |                                                                 |                                     |                                                                                |                                  |                                                                     |
| 4292                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           |                                                                                                                                                             | DUE TO, OR AS A CONSEQUENCE OF                                         |                                                                 |                                     |                                                                                |                                  |                                                                     |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                                                                                        |                                                                                                           |                                                                                                                                                             | (b) <u>Arteriosclerotic cardiovascular disease</u>                     |                                                                 |                                     |                                                                                |                                  |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                             | DUE TO, OR AS A CONSEQUENCE OF                                         |                                                                 |                                     |                                                                                |                                  |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                             | (c)                                                                    |                                                                 |                                     |                                                                                |                                  |                                                                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             |                                                                        |                                                                 |                                     |                                                                                |                                  |                                                                     |
| <u>Cerebral aneurysm ruptured with intracerebral hemorrhage</u>                                                                                                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                             |                                                                        |                                                                 |                                     |                                                                                |                                  |                                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                               |                                                                                                           |                                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                 |                                     | 20a. AUTOPSY?                                                                  |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |
| 10 Oct 83                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                             | Benign Prostatic Hypertrophy                                           |                                                                 |                                     | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                             |                                                                                                           |                                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                 |                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                  |                                                                     |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                         |                                                                                                           |                                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                 |                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                  |                                                                     |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>83</u> to <u>Oct 17</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Oct 17</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                                                                                                           |                                                                                                                                                             | 22b. SIGNATURE<br><u>Henry M. Wise, Jr.</u>                            |                                                                 |                                     | 22c. DATE SIGNED<br>Oct. 18, 1983                                              |                                  |                                                                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                |                                                                                                           |                                                                                                                                                             | 22e. ADDRESS                                                           |                                                                 |                                     |                                                                                |                                  |                                                                     |
| Henry M. Wise, Jr., M.D.                                                                                                                                                                                                                                                                                                                                             |                                                                                                           |                                                                                                                                                             | 2101 Medical Park Drive, #200<br>Silver Spring, Maryland 20902         |                                                                 |                                     |                                                                                |                                  |                                                                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                             | 23b. DATE                                                              |                                                                 |                                     | 23c. NAME OF CEMETERY OR CREMATORY                                             |                                  |                                                                     |
| Cremation                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                             | October 20, 1983                                                       |                                                                 |                                     | Metropolitan Crematory Alexandria Virginia                                     |                                  |                                                                     |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR                                          |                                                                 |                                     | 25b. REGISTRAR'S SIGNATURE                                                     |                                  |                                                                     |
| Robert A. Pumphrey                                                                                                                                                                                                                                                                                                                                                   |                                                                                                           |                                                                                                                                                             | OCT 24 1983                                                            |                                                                 |                                     | <u>John J. Conner</u>                                                          |                                  |                                                                     |
| P.A., Rockville, Maryland                                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                             |                                                                        |                                                                 |                                     |                                                                                |                                  |                                                                     |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO: SAC, NEW YORK  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]

[The remainder of the page contains several paragraphs of extremely faint, illegible text, likely a teletype or memorandum. The text is too light to transcribe accurately.]



*Classified by Medical Examiner*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                           |  | REG. NO.                                                                                                                                                    |  |                                                                                                                            |                                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                           |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                            |  |                                                                                                                            |                                                                  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>GEORGE H. HABERLEN                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                           |  | OCTOBER 12, 1983                                                                                                                                            |  |                                                                                                                            |                                                                  |
| 2. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br>CAUCASIAN                                                                                                                      |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Jan. 19, 1889                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>94 YRS.                                                                                 |                                                                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                                                                     |                                                                  |
| 10. CITY OR TOWN OF DEATH<br>KENSINGTON                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>KENSINGTON GARDENS NURSING HOME |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MERCHANT                                                                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>HARDWARE                                                                              |                                                                  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY<br>MONTGOMERY                                                                                                                 |  | 13c. CITY OR TOWN<br>SILVER SPRING                                                                                                                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |                                                                  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>FRED                                                                                                                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ANNE FURRY                                                                                  |  | 13e. STREET ADDRESS<br>2400 DARROW STREET 20902                                                                                                             |  |                                                                                                                            |                                                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                             |  | 16b. SOCIAL SECURITY NO.<br>064-28-9546                                                                                                   |  | 17. INFORMANT ADDRESS<br>2400 Darrow Street Silver Spring, Md. 20902<br>MARY LOUISE WEEKS - DAUGHTER                                                        |  |                                                                                                                            |                                                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u><br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cerebral arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>30 min<br>20 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><u>Carcinoma of prostate - Carcinoma of Colon</u>                                                                                                                                                                                                               |  |                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                            |                                                                  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                                                                              |  |                                                                                                                            |                                                                  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                       |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                            |                                                                  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/23</u> , 19 <u>76</u> , to <u>10/12</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>10/11</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not) (I) (did not) view the body after death.                                  |  |                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                            |                                                                  |
| 22b. SIGNATURE<br><u>George S. Kenton, MD</u>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                           |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>10/12/83                                                                                               |                                                                  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GEORGE S. KENTON                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                           |  | 22e. ADDRESS<br>10620 Georgia Ave. Silver Spring Md                                                                                                         |  |                                                                                                                            |                                                                  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                 |  | 23b. DATE<br>OCT. 15, 1983                                                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ST. PAUL'S LUTH. CEM.                                                                                                 |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>MT. PLEASANT TWP. WESTMORELAND PA.                                              |                                                                  |
| 24. FUNERAL DIRECTOR NAME<br>FRANCIS J. COLLINS                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                           |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 17 1983                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><u>J. L. L. L.</u>                                                                           |                                                                  |
| 500 UNIVERSITY BLVD. W. SILVER SPRING, MD. 20901                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                            |                                                                  |

Handwritten notes and diagrams on lined paper, including a table with columns labeled "DATE", "TIME", and "PLACE".

| DATE | TIME  | PLACE |
|------|-------|-------|
| 1941 | 10:00 | ...   |
| 1941 | 11:00 | ...   |
| 1941 | 12:00 | ...   |
| 1941 | 13:00 | ...   |
| 1941 | 14:00 | ...   |
| 1941 | 15:00 | ...   |
| 1941 | 16:00 | ...   |
| 1941 | 17:00 | ...   |
| 1941 | 18:00 | ...   |
| 1941 | 19:00 | ...   |
| 1941 | 20:00 | ...   |
| 1941 | 21:00 | ...   |
| 1941 | 22:00 | ...   |
| 1941 | 23:00 | ...   |

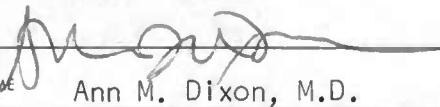

Additional handwritten text and diagrams are present on the page, including a large "X" mark and various scribbles.

Vertical handwritten text on the right margin, possibly a date or page number.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                |  |                                        |                                                                                                                                |                                                                                                                                                             |  |                                                                                                                                 |                                                                       |                                                                           |                         | REG. NO. 27695                                                                      |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                        |                                                                                                                                |                                                                                                                                                             |  |                                                                                                                                 |                                                                       |                                                                           |                         |                                                                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>TREVOR COLE HACKEY                                                                                                                                                                                                                                                                                                                                                                               |  |                                        |                                                                                                                                |                                                                                                                                                             |  | 7a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/><br>MONTH DAY YEAR<br>10 15 19 83 |                                                                       | 7b. HOUR<br>M<br>4:20                                                     |                         |                                                                                     |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>Black                       |                                                                                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 18, 1983                                                                                                        |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br>27                                                                                   |                                                                       | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.                                |                         | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>10 15 19 83                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |                                                                                                                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD                                                                    |                                                                       |                                                                           |                         |                                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br>Gaithersburg                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>10 Maplewood Ct. |                                                                                                                                                             |  |                                                                                                                                 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>None |                                                                           |                         | 12b. KIND OF BUSINESS OR INDUSTRY                                                   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                             |  |                                        |                                                                                                                                |                                                                                                                                                             |  |                                                                                                                                 |                                                                       |                                                                           |                         |                                                                                     |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br>Montg.                  |                                                                                                                                | 13c. CITY OR TOWN<br>Gaithersburg.                                                                                                                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                            |                                                                       | 13e. STREET ADDRESS<br>10 Maplewood Court 20877                           |                         |                                                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Hackey                                                                                                                                                                                                                                                                                                                                                                                               |  |                                        |                                                                                                                                |                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Kathy Lynn Wells                                                               |                                                                       |                                                                           |                         |                                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                            |  |                                        |                                                                                                                                | 16b. SOCIAL SECURITY NO.<br>None                                                                                                                            |  | 17. INFORMANT<br>ADDRESS<br>Charles Hackey (father) same as #13                                                                 |                                                                       |                                                                           |                         |                                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). <u>Sudden Infant Death Syndrome</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                                    |  |                                        |                                                                                                                                |                                                                                                                                                             |  |                                                                                                                                 |                                                                       |                                                                           |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                                                                                                                                                                                                                                                                                                                    |  |                                        |                                                                                                                                |                                                                                                                                                             |  |                                                                                                                                 |                                                                       |                                                                           |                         |                                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                        |                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                           |  |                                                                                                                                 |                                                                       |                                                                           |                         | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                 |  |                                        |                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                   |                                                                       |                                                                           |                         |                                                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                         |  |                                        |                                                                                                                                | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                               |                                                                       |                                                                           |                         |                                                                                     |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                                        |                                                                                                                                |                                                                                                                                                             |  |                                                                                                                                 |                                                                       |                                                                           |                         |                                                                                     |  |
| ACTUAL SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                                |  |                                        |                                                                                                                                |                                                                                                                                                             |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER                                                                              |                                                                       |                                                                           | DATE SIGNED<br>10-15-83 |                                                                                     |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                        |                                                                                                                                |                                                                                                                                                             |  | ADDRESS<br>111 Penn St., Balto., Md. 21201                                                                                      |                                                                       |                                                                           |                         |                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                        |                                                                                                                                | 23b. DATE<br>10-19-83                                                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br>John Wesley Cemetery                                                                      |                                                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Clarksburg, Montg. Maryland |                         |                                                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>George R. Snowden                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                        |                                                                                                                                |                                                                                                                                                             |  | ADDRESS<br>246 N. Washington St.<br>Rockville, Md. 20850                                                                        |                                                                       | 25a. DATE REC'D. BY REGISTRAR<br>OCT 20 1983                              |                         |                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                        |                                                                                                                                |                                                                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE<br>             |                                                                       |                                                                           |                         |                                                                                     |  |





BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                |  |                                  |  |                                                                                                                                               |  |                                                                                              |  |                                                                                                                                                             |  | 27596                                                                                          |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                  |  |                                                                                                                                               |  |                                                                                              |  |                                                                                                                                                             |  | REG. NO.                                                                                       |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Robert A. HANSEN, SR.</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                  |  |                                                                                                                                               |  |                                                                                              |  |                                                                                                                                                             |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>10 1 1983</b> |  |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>white</b>          |  | 5. DATE OF BIRTH (MONTH DAY YEAR)<br><b>July 17, 1929</b>                                                                                     |  | 6. AGE (IN YEARS) (LAST BIRTHDAY)<br><b>54 YRS.</b>                                          |  | IF UNDER 1 YR. MONTHS DAYS<br><b>0 0</b>                                                                                                                    |  | IF UNDER 24 HRS. HOURS MIN.<br><b>0 0</b>                                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wisconsin</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                    |  |                                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b>                                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Gaithersburg</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Shady Grove Adventist Hosp.</b> |  |                                                                                              |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Management Analyst</b>                                                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Navy Dept.</b>                                         |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                             |  |                                  |  |                                                                                                                                               |  |                                                                                              |  |                                                                                                                                                             |  |                                                                                                |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY<br><b>Montgomery</b> |  | 13c. CITY OR TOWN<br><b>Rockville</b>                                                                                                         |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>13103 Okinawa Avenue</b>                                                                                                          |  |                                                                                                |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Russell Hansen</b>                                                                                                                                                                                                                                                                                                                                                                                           |  |                                  |  |                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Martha Hintz</b>                            |  |                                                                                                                                                             |  |                                                                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                                                                       |  |                                  |  | 16b. SOCIAL SECURITY NO.<br><b>WW II 396-24-7423</b>                                                                                          |  | 17. INFORMANT ADDRESS<br><b>Robert A. Hansen, Jr., 13103 Okinawa Ave. Rockville, Md.</b>     |  |                                                                                                                                                             |  |                                                                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br><b>4140</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>coronary arteriosclerosis</b><br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                       |  |                                  |  |                                                                                                                                               |  |                                                                                              |  |                                                                                                                                                             |  |                                                                                                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____                                                                                                                                                                                                                                                                                                               |  |                                  |  |                                                                                                                                               |  |                                                                                              |  |                                                                                                                                                             |  |                                                                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                             |  |                                                                                              |  |                                                                                                                                                             |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                    |  |                                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>                                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |                                                                                                                                                             |  |                                                                                                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                               |  |                                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                                                                                                             |  |                                                                                                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                                  |  |                                                                                                                                               |  |                                                                                              |  |                                                                                                                                                             |  |                                                                                                |  |
| ACTUAL SIGNATURE<br><b>John Tauber</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                  |  | TITLE (SPECIFY)<br><b>M.D.</b>                                                                                                                |  |                                                                                              |  | MEDICAL EXAMINER<br><b>8218 WISCONSIN</b>                                                                                                                   |  |                                                                                                |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>John Tauber</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                  |  | ADDRESS<br><b>8218 WISCONSIN</b>                                                                                                              |  |                                                                                              |  | DATE SIGNED<br><b>10-1-83</b>                                                                                                                               |  |                                                                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                  |  | 23b. DATE<br><b>10-5-1983</b>                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee Crematory</b>                                   |  |                                                                                                                                                             |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Washington, D.C.</b>                             |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Danzansky-Goldberg Mem. Chapels; 1170 Rockville Pike</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                  |  |                                                                                                                                               |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 6 1983</b>                                           |  |                                                                                                                                                             |  |                                                                                                |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. White</b>                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                  |  |                                                                                                                                               |  |                                                                                              |  |                                                                                                                                                             |  |                                                                                                |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                   |                                                                                                                                         |                                                                                                                                                             |                                                                                                 |                                                               |                                                                  |
|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------|------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Edith M. Hanson</i>   |                                                                                                                                         |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>10/27/83</i>                                             |                                                               | 2b. HOUR<br><i>8:45 AM</i>                                       |
| 3. SEX<br><i>Female</i>                                                           | 4. RACE<br><i>White</i>                                                                                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>12/16/02</i>                                                                                                       |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>80</i> YRS.             | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><i>England</i>                    | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD. |                                                                  |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Holy Cross Hospital</i> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>            |                                                               | 12b. KIND OF BUSINESS OR INDUSTRY                                |
| 13a. USUAL RESIDENCE<br>13a. STATE<br><i>Maryland</i>                             | 13b. COUNTY<br><i>Montgomery</i>                                                                                                        | 13c. CITY OR TOWN<br><i>Rockville</i>                                                                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><i>17630 Viers Mill Road # 1620</i>    |                                                                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>ERNEST John Elliott</i>              |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Maria HODGE</i>                                                                                         |                                                                                                 |                                                               |                                                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i> |                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br><i>082 03 9370</i>                                                                                                              |                                                                                                 | 17. INFORMANT<br><i>Edward H. Hanson Husband</i>              |                                                                  |
|                                                                                   |                                                                                                                                         |                                                                                                                                                             |                                                                                                 | ADDRESS<br><i>Same as 13</i>                                  |                                                                  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*4413*  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) *Hypotensive shock*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Ruptured Abdominal Aortic Aneurysm*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH*10-15 minutes**8 hrs**9 hrs*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

*Acute Diverticulitis*

|                                                                                                                                                                                                                                                                                                                                                                                |                                                                                               |                                                                                      |                                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION<br><i>Oct 27, 83</i>                                                                                                                                                                                                                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Ruptured Abdominal Aortic Aneurysm</i> | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                    | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 26</i> , 19 <i>83</i> , to <i>Oct 27</i> , 19 <i>83</i> , that (I) (we) last<br>saw the deceased alive on <i>Oct 27</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |                                                                                               |                                                                                      |                                                                                                                               |
| 22b. SIGNATURE<br><i>MARQUEZ</i>                                                                                                                                                                                                                                                                                                                                               |                                                                                               | DEGREE                                                                               | 22c. DATE SIGNED<br><i>Oct 27, 83</i>                                                                                         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>JAMES F. MARQUEZ</i>                                                                                                                                                                                                                                                                                                               |                                                                                               | 22e. ADDRESS<br><i>831 University Blvd (E) Silver Spring Md</i>                      |                                                                                                                               |

|                                                                  |                          |                                                                                         |                                            |
|------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Cremation</i> | 23b. DATE<br><i>1983</i> | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Metropolitan Crematory Alexandria Virginia</i> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Francis J. Collins</i>        |                          | 25a. DATE REC'D BY REGISTRAR<br><i>OCT 31 1983</i>                                      |                                            |
| 500 University Blvd., W. Silver Spring, Md.                      |                          | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Collins</i>                                    |                                            |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                               |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                          |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR                                                                      |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR                                                                      |                                              |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                               |                                                                                                        | MONTH DAY YEAR                                                                                                                                           |                                                                     | HOURS MIN.                                                                    |                                              |
| Israel JERRY Harab.                                                                                                                                                                                                                                                                             |                                                                                                        | 10/16/83                                                                                                                                                 |                                                                     | 7:45 M                                                                        |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                          | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 8. IF UNDER 1 YEAR                                                            |                                              |
| Male                                                                                                                                                                                                                                                                                            | WHITE                                                                                                  | MONTH DAY YEAR                                                                                                                                           | 66                                                                  | IF UNDER 24 HRS                                                               |                                              |
|                                                                                                                                                                                                                                                                                                 | Jewish                                                                                                 | 11 17 1916                                                                                                                                               |                                                                     | MONTHS                                                                        | DAYS HOURS MIN.                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                       | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                                                               |                                              |
| ROMANIA                                                                                                                                                                                                                                                                                         | USA                                                                                                    |                                                                                                                                                          | MONTGOMERY COUNTY MD.                                               |                                                                               |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Beth Md.                                                                                                                                                                                                                                                                                        | Suburban Hospital                                                                                      |                                                                                                                                                          | Retired                                                             |                                                                               | U.S. C.P.A. GOVT.                            |
| 13a. STATE                                                                                                                                                                                                                                                                                      |                                                                                                        | 13b. COUNTY                                                                                                                                              | 13c. CITY OR TOWN                                                   | 13d. STREET ADDRESS                                                           |                                              |
| MD.                                                                                                                                                                                                                                                                                             | MONTG.                                                                                                 | ROCKVILLE                                                                                                                                                | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 10500 ROCKVILLE PK.                                                           |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                               |                                                                                                        | 15. MOTHER'S MAIDEN NAME                                                                                                                                 |                                                                     |                                                                               |                                              |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                               |                                                                                                        | FIRST MIDDLE LAST                                                                                                                                        |                                                                     |                                                                               |                                              |
| MORRIS ----- HARAB                                                                                                                                                                                                                                                                              |                                                                                                        | SAIDI ----- KRUPNICK                                                                                                                                     |                                                                     |                                                                               |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)                                                                                                                                                                                                                                   |                                                                                                        | 16b. SOCIAL SECURITY NO.                                                                                                                                 |                                                                     | 17. INFORMANT ADDRESS                                                         |                                              |
| NO                                                                                                                                                                                                                                                                                              |                                                                                                        | NONE                                                                                                                                                     |                                                                     | 577-36-449                                                                    |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1: DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                               |                                              |
| IMMEDIATE CAUSE (a)                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                               | 1 year.                                      |
| 1519                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                               |                                              |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                               |                                              |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                               |                                              |
| (b)                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                               |                                              |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                               |                                              |
| (c)                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                               |                                              |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                              |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                               |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                          |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                                     | 20a. AUTOPSY?                                                                 |                                              |
|                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                          |                                                                     | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                              |                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                                                                             |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                              |
|                                                                                                                                                                                                                                                                                                 |                                                                                                        | P.M. 19                                                                                                                                                  |                                                                     |                                                                               |                                              |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                          |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                     | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |                                              |
|                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                               |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/15/83 to 10/16/83, that (I) (we) lost saw the deceased (I) (we) (did) (did not) view the body after death. 10/15/83, and that my (my) (our) opinion death occurred on the date and hour and from the causes stated above. |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                               |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                  |                                                                                                        | DEGREE                                                                                                                                                   |                                                                     | 22c. DATE SIGNED                                                              |                                              |
| Sanford N. Richman, M.D.                                                                                                                                                                                                                                                                        |                                                                                                        | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |                                                                     | 10/16/83.                                                                     |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                           |                                                                                                        | 22e. ADDRESS                                                                                                                                             |                                                                     |                                                                               |                                              |
| SANFORD N. RICHMAN MD                                                                                                                                                                                                                                                                           |                                                                                                        | 11500 Old Georgetown Rd. Rock Md                                                                                                                         |                                                                     |                                                                               |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                       |                                                                                                        | 23b. DATE                                                                                                                                                | 23c. NAME OF CEMETERY OR CREMATORY                                  |                                                                               | 23d. LOCATION CITY OR TOWN COUNTY STATE      |
| BURIAL                                                                                                                                                                                                                                                                                          |                                                                                                        | 10-17-83                                                                                                                                                 | NAT'L CAP. HEBREW                                                   |                                                                               | CAPITAL HEIGHTS, MD.                         |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                       |                                                                                                        | 24b. ADDRESS                                                                                                                                             |                                                                     | DATE REC'D. BY REGISTRAR                                                      |                                              |
| 1170 ROCKVILLE PK. ROCKVILLE MD                                                                                                                                                                                                                                                                 |                                                                                                        | DANZANSKY-GOLDBERG MEM CHP, INC.                                                                                                                         |                                                                     | OCT 28 1983                                                                   |                                              |
|                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                          |                                                                     | 25b. REGISTRAR'S SIGNATURE                                                    |                                              |
|                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                          |                                                                     | C. E. Casper                                                                  |                                              |

STANDARD FORM NO. 64

STANDARD FORM NO. 64

STANDARD FORM NO. 64

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                        |                                                                                                                                                             |                                                                                                      |                                                                                      |                                                                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Mary Durette Hardy.</b>                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Oct. 28, 1983</b>                                             |                                                                                      | 2b. HOUR<br><b>11 P.M.</b>                                                                      |  |
| 3. SEX<br><b>Female.</b>                                                                                                                                                                                                                                                                                                                                                                                                                   | 4. RACE<br><b>white.</b>                                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 21, 1912</b>                                                                                                  |                                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b><br>YRS. MONTHS DAYS                     |                                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia.</b>                                                                                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery.</b> MD.                       |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park.</b>                                                                                                                                                                                                                                                                                                                                                                                           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(GIVE FULL STREET ADDRESS)<br><b>6901 Westmoreland Ave.</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired, Fed. Government.</b> |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                        |                                                                                                                        |                                                                                                                                                             | 13b. COUNTY<br><b>Montg.</b>                                                                         | 13c. CITY OR TOWN<br><b>Takoma Park</b>                                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas T. Hardy.</b>                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Gillis.</b>                            |                                                                                      |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b>                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                        | 16b. SOCIAL SECURITY NO.<br><b>Not Available</b>                                                                                                            |                                                                                                      | 17. INFORMANT ADDRESS<br><b>Elizabeth Pugh, (Niece) 6608 West-</b>                   |                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular Pulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinoma colon &amp; Metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary Artery disease</b><br>1539<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                                                                                                                        |                                                                                                                                                             |                                                                                                      |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Anemia, Dehydration Renal Insufficiency</b>                                                                                                                                                                                                                                                            |                                                                                                                        |                                                                                                                                                             |                                                                                                      |                                                                                      |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                 |                                                                                                                        |                                                                                                                                                             |                                                                                                      |                                                                                      |                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                   |                                                                                                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                                      | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |                                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                               |                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/8/83</b> to <b>10/29/83</b> , that (I) (we) lost<br>saw the deceased alive on <b>10/8/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                                                        |                                                                                                                        |                                                                                                                                                             |                                                                                                      |                                                                                      |                                                                                                 |  |
| 22b. SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                        | DEGREE<br><b>M.D.</b>                                                                                                                                       |                                                                                                      | 22c. DATE SIGNED                                                                     |                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VIVEK C VAID</b>                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                        | 22e. ADDRESS<br><b>7676 New Hampshire Ave Hyattsville</b>                                                                                                   |                                                                                                      |                                                                                      |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial.</b>                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                        | 23b. DATE<br><b>Nov. 1, 1983</b>                                                                                                                            |                                                                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>                              |                                                                                                 |  |
| 23d. LOCATION<br><b>Suitland, P.G. Co. Md.</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                        |                                                                                                                                                             |                                                                                                      |                                                                                      |                                                                                                 |  |
| 24. FUNERAL DIRECTOR<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                        | 25. ADDRESS<br><b>254 Carroll St. N. W. Takoma Funeral Home.</b>                                                                                            |                                                                                                      | 26. DATE REC'D. BY REGISTRAR<br><b>NOV 2 1983</b>                                    |                                                                                                 |  |
| 27. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                        |                                                                                                                                                             |                                                                                                      |                                                                                      |                                                                                                 |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 (pay) be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



5.2

546 J. L. M.

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• *Journal of Management Education* 30(10):1039-1050

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                      |                                                                      | REG. NO.                                                                                                                   |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Victor Monroe HARKAVY                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  |                                                                                                                                                             |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 - 30 - 83                                                                                                     |  |                                                                                      | 2b. HOUR <sup>EST</sup><br>0143 M                                    |                                                                                                                            |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br>White                                                                                                                             |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 6, 1908                                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.                                                                                                           |  |                                                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.     |                                                                                                                            |  |
| 7a. BIRTHPLACE<br>STATE OR FOREIGN COUNTRY<br>New York City                                                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                                                                                                     |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                                                                                               |  |                                                                                      |                                                                      |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Shady Grove                                                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SHADY GROVE ADJUNCTIST HOSPITAL |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Systems Analyst                                                                  |  |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Govt.                      |                                                                                                                            |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Maryland Montgomery Potomac                                                                                                                                                                                                                                                         |  |                                                                                                                                              |  |                                                                                                                                                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                      |  | 13e. STREET ADDRESS<br>9305 Falls Chapel Way 20854                                   |                                                                      |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Aaron Harkavy                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rose Bloom                                                                                                 |  |                                                                                                                                                      |  |                                                                                      |                                                                      |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                 |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>091-10-7695                                                                       |  | 17. INFORMANT<br>Nedra I. Harkavy (Same as # 13)                                                                                                            |  |                                                                                                                                                      |  | ADDRESS                                                                              |                                                                      |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4100 CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>IMMED<br>2 HOURS |  |                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                      |                                                                      |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a                                                                                                                                                                                                                                                                                          |  |                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                      |                                                                      |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                                                                                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                   |  |                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |  |                                                                                      |                                                                      |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                      |                                                                      |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                                                                                          |  |                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                      |                                                                      |                                                                                                                            |  |
| 22b. SIGNATURE<br>Don M. Wiseman M.D.                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  |                                                                                                                                                             |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>10/30/1983                                                       |                                                                      |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Don M. Wiseman, M.D.                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  |                                                                                                                                                             |  | 22e. ADDRESS<br>5410 CONNECTICUT AVE, N.W. WASH; DC 20015                                                                                            |  |                                                                                      |                                                                      |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                              |  | 23b. DATE<br>11/1/1983                                                                                                                                      |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Judean Memorial Gardens                                                                                        |  |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Olney, Montgomery, Md. |                                                                                                                            |  |
| 24a. NAME OF FUNERAL HOME<br>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME<br>232 Carroll Street, N. W., Washington, D. C.                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                              |  |                                                                                                                                                             |  | 24b. DATE RECEIVED BY REGISTRAR<br>NOV 7 1983                                                                                                        |  | 24c. REGISTRAR'S SIGNATURE<br>John J. Carver                                         |                                                                      |                                                                                                                            |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                        |                                                                                                                                                             |                                                                               |                                                                                                 |                                                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Petroura T. Harris                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10-3-83                                |                                                                                                 | 2b. HOUR<br>1:20 AM                                                                                                                   |
| 3. SEX<br>F                                                                                                                                                                                                                                                                                                                                                                                                         | 4. RACE<br>C.                                                                                                                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 15 04                                                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                       |                                                                                                                                       |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Greece                                                                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.                                                                                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                        |                                                                                                 |                                                                                                                                       |
| 10. CITY OR TOWN OF DEATH<br>Takoma Park                                                                                                                                                                                                                                                                                                                                                                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Washington Adventist Hosp |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY<br>own home                                                   |                                                                                                                                       |
| 13a. STATE<br>md.                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                        | 13b. COUNTY<br>Montgomery                                                                                                                                   | 13c. CITY OR TOWN<br>Takoma Park                                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>7803 Lockney Ave.                                                                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Lucas - Skodes                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bessie - Skodes              |                                                                                                 |                                                                                                                                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                        | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>577-34-1755-B                                                                                   |                                                                               | 17. INFORMANT<br>ADDRESS<br>John Samartzis-Friend- 1014 Anne Ave.,<br>Takoma Park, Md. 20912    |                                                                                                                                       |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Sharp - <del>Penetration</del><br>5751<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) Hepatic - Perforated Foreline<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Perforation of Liver<br>Yrs |                                                                                                                                        |                                                                                                                                                             |                                                                               |                                                                                                 |                                                                                                                                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Cerebral hemorrhage                                                                                                                                                                                                                                                             |                                                                                                                                        |                                                                                                                                                             |                                                                               |                                                                                                 |                                                                                                                                       |
| 19a. DATE OF OPERATION<br>9/14                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Cholelithiasis & C.D.S.                                                                                 |                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                            |                                                                                                                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                                                                       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                  |                                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                                       |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/31/1955 to 10/3/1983, that (I) (we) last saw the deceased alive on 10/3/1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                         |                                                                                                                                        |                                                                                                                                                             |                                                                               |                                                                                                 |                                                                                                                                       |
| 22b. SIGNATURE<br>H. L. Marter                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                        | DEGREE<br>M.D.                                                                                                                                              |                                                                               | 22c. DATE SIGNED<br>10/3/83                                                                     |                                                                                                                                       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. L. MARTER, MD                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                        | 22e. ADDRESS<br>831 University Blvd E. S.S. Md.                                                                                                             |                                                                               |                                                                                                 |                                                                                                                                       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                              | 23b. DATE<br>10-5-1983                                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven                                                                                                        |                                                                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Silver Spring Montgomery Md.                      |                                                                                                                                       |
| 24. FUNERAL DIRECTOR<br>Hines/Rinaldi Funeral Home                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                        | 11800 N.H. Ave.,<br>Silver Spring, Md.                                                                                                                      |                                                                               | OCT 4 1983                                                                                      |                                                                                                                                       |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

James/Kimberly Funeral Home 11800 W.E. Ave.,  
Silver Spring, Md.  
10-3-1983 Date of Heaven

Silver Spring Home away, Md.  
2.2.83

E/A

577-24-1755

John Kenneth - Friend -

1014 Anne Ave.,  
Takoma Park, Md. 20912

Montgomery

City Home

Montgomery

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                              |  |                     |                                                                                                                                          |                                                                 |  |                                                                                                                                                             |  |                                                   |                                                                                                                         |                                                   |  |                                                                |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------|------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|--|----------------------------------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ruth C. Harvey</b>                                                                                                                                                                                                                                                                                                                                                    |  |                     | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>1</b> YEAR <b>83</b>                                                                         |                                                                 |  | 2b. HOUR<br><b>5:12 P<sup>M</sup></b>                                                                                                                       |  |                                                   |                                                                                                                         |                                                   |  |                                                                |  |  |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><b>W</b> |                                                                                                                                          | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>05</b> YEAR <b>04</b> |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.                                                                                                           |  | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> |                                                                                                                         | 8. IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> |  |                                                                |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, D.C.</b>                                                                                                                                                                                                                                                                                                                                         |  |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                               |                                                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                                           |                                                   |  |                                                                |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                                                                                                                                                                                                                                                                                                                                                            |  |                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital,</b> |                                                                 |  |                                                                                                                                                             |  |                                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sect. retired</b>                                |                                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>US Govt.</b>           |  |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                     | 13b. COUNTY<br><b>Montgomery</b>                                                                                                         |                                                                 |  | 13c. CITY OR TOWN<br><b>Silver Spring</b>                                                                                                                   |  |                                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |                                                   |  | 13e. STREET ADDRESS<br><b>1311 Mullins Street 20904</b>        |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Willard</b> MIDDLE <b></b> LAST <b>Hahn</b>                                                                                                                                                                                                                                                                                                                                    |  |                     | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Minnie</b> MIDDLE <b>P.</b> LAST <b>Morrison</b>                                                    |                                                                 |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>N/A</b>                                                                             |  |                                                   | 16b. SOCIAL SECURITY NO.<br><b>218-20-1404</b>                                                                          |                                                   |  | 17. INFORMANT<br><b>Nancy R. Waters-daughter-(same as 13e)</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive Cerebral infarct</b><br><b>4349</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cerebral Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                     |                                                                                                                                          |                                                                 |  |                                                                                                                                                             |  |                                                   |                                                                                                                         |                                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 weeks</b> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Anteriorly located Heart disease with Chronic Atrial Fibrillation</b>                                                                                                                                                                                             |  |                     |                                                                                                                                          |                                                                 |  |                                                                                                                                                             |  |                                                   |                                                                                                                         |                                                   |  |                                                                |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                       |  |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |                                                                 |  | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  |                                                   | 19d. YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                   |  |                                                                |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                     |  |                     | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                        |                                                                 |  | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                   | 20d. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                       |                                                   |  |                                                                |  |  |
| 21a. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                    |  |                     | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |                                                                 |  | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                   | 21d. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                       |                                                   |  |                                                                |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>8-1-83</b> , 19 <b>83</b> , to <b>10-1</b> , 19 <b>83</b> , that (1) (we) last saw the deceased alive on <b>10-1-83</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.                                        |  |                     |                                                                                                                                          |                                                                 |  |                                                                                                                                                             |  |                                                   |                                                                                                                         |                                                   |  |                                                                |  |  |
| 22b. SIGNATURE<br><b>Morris Perry M.D.</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                     | DEGREE<br><b>M.D.</b>                                                                                                                    |                                                                 |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |                                                   | 22c. DATE SIGNED<br><b>10-1-83</b>                                                                                      |                                                   |  |                                                                |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Morris Perry M.D.</b>                                                                                                                                                                                                                                                                                                                                            |  |                     | 22e. ADDRESS<br><b>11602 Georgia Ave, Silver Spring Md 20902</b>                                                                         |                                                                 |  | 22f. ADDRESS<br><b>11602 Georgia Ave, Silver Spring Md 20902</b>                                                                                            |  |                                                   | 22g. ADDRESS<br><b>11602 Georgia Ave, Silver Spring Md 20902</b>                                                        |                                                   |  |                                                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                   |  |                     | 23b. DATE<br><b>10/5/83</b>                                                                                                              |                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>                                                                                             |  |                                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlington</b>                                                          |                                                   |  |                                                                |  |  |
| 24. FUNERAL DIRECTOR<br><b>Hines/Rinaldi Funeral Home</b>                                                                                                                                                                                                                                                                                                                                                    |  |                     | 24a. ADDRESS<br><b>11800 N.H. Ave., Sil. Spr. Md. 20904</b>                                                                              |                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 4 - 1983</b>                                                                                                        |  |                                                   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                                                     |                                                   |  |                                                                |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1100 N.H. Ave.  
St. Spr. Md. 20701-4

1100 N.H. Ave.  
St. Spr. Md. 20701-4

1100 N.H. Ave.  
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1100 N.H. Ave.  
St. Spr. Md. 20701-4



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                |  |                                                                                                                                                |                                                                        |                                                                                                                                                             |                                                                       |                                                                                      |                                                                                      |                                                                 |                                                    |  |
|--------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HELEN F. HAYDEN</b>                     |  |                                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>OCTOBER 26 1983</b>             |                                                                                                                                                             |                                                                       | 2b. HOUR<br><b>4:52 a.m.</b>                                                         |                                                                                      |                                                                 |                                                    |  |
| 3. SEX<br><b>Female</b>                                                        |  | 4. RACE<br><b>White</b>                                                                                                                        |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>11 22 11</b>                                                                                                          |                                                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b>                                         |                                                                                      | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                    |                                                    |  |
| 7a. BIRTHPLACE<br>STATE OR FOREIGN COUNTRY <b>RHODE ISLAND</b>                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                                    |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b>                 |                                                                                      |                                                                 |                                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hosp.</b> |                                                                        |                                                                                                                                                             |                                                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b> |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Applied Physics Lab</b> |                                                    |  |
| 13a. STATE<br><b>Md.</b>                                                       |  |                                                                                                                                                | 13b. COUNTY<br><b>Montgomery</b>                                       |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Silver Spring</b>                             |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                 | 13e. STREET ADDRESS<br><b>407 Lanark Way 20901</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Dennis Fole</b>                   |  |                                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Sullivan</b> |                                                                                                                                                             |                                                                       |                                                                                      |                                                                                      |                                                                 |                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b> |  |                                                                                                                                                | 16b. SOCIAL SECURITY NO.<br><b>218-38-9326</b>                         |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>ROGER M. HAYDEN HUSBAND SAME AS 13</b> |                                                                                      |                                                                                      |                                                                 |                                                    |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARCINOMA OF LUNG****1629**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
**9 months**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                        |  |                                                                                      |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/20</b> , 19 <b>83</b> , to <b>10/26</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>10/25</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Kirkland C. Brace</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                        |  | DEGREE<br><b>MD</b>                                                                  |  | 22c. DATE SIGNED<br><b>10/26/83</b>                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KIRKLAND C. BRACE</b>                                                                                                                                                                                                                                                                                                           |  |                                                                        |  | 22e. ADDRESS<br><b>1600 Carroll Ave, Takoma Park, MD</b>                             |  |                                                                                                                            |  |

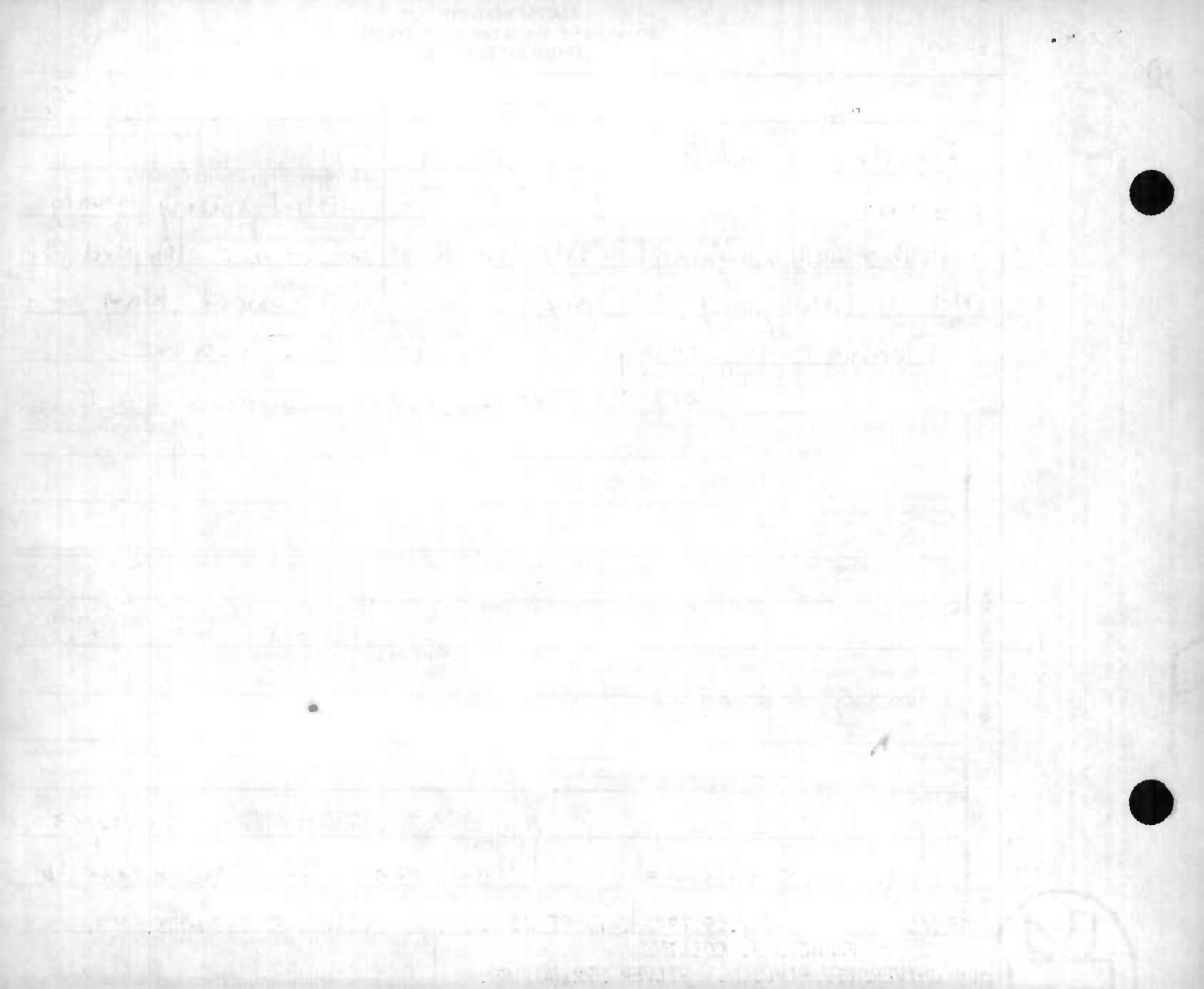
|                                                                                                                      |  |                                   |  |                                                             |  |                                                                              |  |
|----------------------------------------------------------------------------------------------------------------------|--|-----------------------------------|--|-------------------------------------------------------------|--|------------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>                                                           |  | 23b. DATE<br><b>OCT. 29, 1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GATE OF HEAVEN</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SILVER SPRING MONT. MD.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>FRANCIS J. COLLINS</b><br>ADDRESS <b>500 UNIVERSITY BLVD., W. SILVER SPRING, MD.</b> |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 31 1983</b>         |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                          |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                 |                                                        |                                                                                                                                                             |                           |                                                                                                 |  |                                                                                                                            |  |                                                               |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Rose Herbert Hayden</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                 | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 10 83</b> |                                                                                                                                                             | 2b. HOUR<br><b>6:00AM</b> |                                                                                                 |  |                                                                                                                            |  |                                                               |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>Caucasian</b>                                                                                                                     |                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 8 1912</b>                                                                                                    |                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>70</b>                                             |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>                                                                               |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b>                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, D.C.</b>                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                            |                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD</b>                             |  |                                                                                                                            |  |                                                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |                                                        |                                                                                                                                                             |                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Agriculture</b>                                                                    |  |                                                               |  |
| 13a. STATE<br><b>Washington DC</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY<br><b>Wash. D.C.</b>                                                                                                                |                                                        | 13c. CITY OR TOWN<br><b>Wash. D.C.</b>                                                                                                                      |                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1011 Independence Av.</b>                                                                        |  | zip - <b>20033-9999</b>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albert Courtney Hayden, Sr</b>                                                                                                                                                                                                                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rose Herbert</b>                                                                            |                                                        | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                                                                           |                           | 16b. SOCIAL SECURITY NO.<br><b>57760 1556M</b>                                                  |  | 17. INFORMANT<br><b>Mary A. Hayden, 18430 Brooke Grove Road Olney, Md. 20832</b>                                           |  |                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Aspiration Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute Myocardial Infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                                 |                                                        |                                                                                                                                                             |                           |                                                                                                 |  |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9 days</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:<br><b>Stroke</b>                                                                                                                                                                                                                                                     |  |                                                                                                                                                 |                                                        |                                                                                                                                                             |                           |                                                                                                 |  |                                                                                                                            |  |                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                |                                                        |                                                                                                                                                             |                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                               |                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                           |                                                                                                 |  |                                                                                                                            |  |                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                          |                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                           |                                                                                                 |  |                                                                                                                            |  |                                                               |  |
| 22a. I certify that (i) (his hospital) attended the deceased from <b>10-1</b> , 19 <b>83</b> , to <b>10-10</b> , 19 <b>83</b> , that (i) (we) lost<br>saw the deceased alive on <b>10-9</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (i) (we) (did) (did not) view the body after death.                               |  |                                                                                                                                                 |                                                        |                                                                                                                                                             |                           |                                                                                                 |  |                                                                                                                            |  |                                                               |  |
| 22b. SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                   |  | DEGREE                                                                                                                                          |                                                        | ATTENDING MEDICAL STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>               |                           |                                                                                                 |  | 22c. DATE SIGNED<br><b>10-10-83</b>                                                                                        |  |                                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. ROTSTAIN</b>                                                                                                                                                                                                                                                                                                                                            |  | 22e. ADDRESS<br><b>10401 Old Georgetown Rd Bethesda Md</b>                                                                                      |                                                        |                                                                                                                                                             |                           |                                                                                                 |  |                                                                                                                            |  |                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br><b>Oct. 14, 1983</b>                                                                                                               |                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>                                                                                            |                           | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>Suitland, Prince George, Md.</b>                     |  |                                                                                                                            |  |                                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                 |                                                        | ADDRESS<br><b>Funeral Homes, P.A. Bethesda, Maryland</b>                                                                                                    |                           | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 13 1983</b>                                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                           |  |                                                               |  |

RECEIVED

UNITED STATES DEPARTMENT OF THE ARMY  
WASHINGTON, D. C. 20315

10 10 53 8:00 AM

ROBERT L. T. BAYDEN

|           |                     |
|-----------|---------------------|
| NAME      | ROBERT L. T. BAYDEN |
| DATE      | 10 10 53            |
| TIME      | 8:00 AM             |
| LOCATION  |                     |
| REASON    |                     |
| REMARKS   |                     |
| SIGNATURE |                     |
| OFFICE    |                     |
| UNIT      |                     |
| GRADE     |                     |
| BRANCH    |                     |
| POST      |                     |
| STATE     |                     |
| COUNTRY   |                     |
| ZIP       |                     |
| TELEPHONE |                     |
| TELETYPE  |                     |
| FAX       |                     |
| EMAIL     |                     |
| WEBSITE   |                     |
| ADDRESS   |                     |
| CITY      |                     |
| STATE     |                     |
| COUNTRY   |                     |
| ZIP       |                     |
| TELEPHONE |                     |
| TELETYPE  |                     |
| FAX       |                     |
| EMAIL     |                     |
| WEBSITE   |                     |

*Handwritten notes:*  
1. [illegible]  
2. [illegible]  
3. [illegible]  
4. [illegible]  
5. [illegible]  
6. [illegible]  
7. [illegible]  
8. [illegible]  
9. [illegible]  
10. [illegible]

100% COLLECTIBLE



UNITED STATES DEPARTMENT OF THE ARMY

WASHINGTON, D. C. 20315

10 10 53 8:00 AM

ROBERT L. T. BAYDEN

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                    |                                                                                                                                                                   |                                                                                    |                                                                                      |                                                                                                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LAWRENCE MICHAEL HEALY</b>                                                                                                                                                                                                                                                                                                                       |                                                                                                                                    |                                                                                                                                                                   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 28 1983</b>                      |                                                                                      | 2b. HOUR<br><b>3:12 P.M.</b>                                                                                                             |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                      | 4. RACE<br><b>CAUCASIAN</b>                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>SEPTEMBER 20 1932</b>                                                                                                    |                                                                                    | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>51</b> YRS.                                  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                                          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NY</b>                                                                                                                                                                                                                                                                                                                                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                               | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |                                                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY MD.</b>                        |                                                                                                                                          |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>                                                                                                                                                                                                                                                                                                                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NAVAL HOSPITAL</b> |                                                                                                                                                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b> |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. NAVY</b>                                                                                    |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                   |                                                                                                                                    |                                                                                                                                                                   | 13b. COUNTY<br><b>ST. MARY'S</b>                                                   | 13c. CITY OR TOWN<br><b>LEXINGTON PARK</b>                                           | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LAWRENCE ALOYSIUS HEALY</b>                                                                                                                                                                                                                                                                                                                   |                                                                                                                                    |                                                                                                                                                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARGARET BURKE</b>             |                                                                                      |                                                                                                                                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                                                                                         |                                                                                                                                    | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>1951-1978</b>                                                                                       |                                                                                    | 17. INFORMANT<br>ADDRESS<br><b>COLEEN A. HICKEY, 124 LAKE AVENUE, YONKERS,</b>       |                                                                                                                                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>NEW YORK 10703</b><br><b>4254</b><br>IMMEDIATE CAUSE (a) <b>SEVERE CONGESTIVE CARDIOMYOPATHY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                              |                                                                                                                                    |                                                                                                                                                                   |                                                                                    |                                                                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                                          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                       |                                                                                                                                    |                                                                                                                                                                   |                                                                                    |                                                                                      |                                                                                                                                          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                  |                                                                                    | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                   |                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                        |                                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                                          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                               |                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                            |                                                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                                          |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 20</b> , 19 <b>83</b> , to <b>OCTOBER 28</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>OCTOBER 28</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |                                                                                                                                    |                                                                                                                                                                   |                                                                                    |                                                                                      |                                                                                                                                          |
| 22b. SIGNATURE<br><i>L. Hall</i>                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                    | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                    | 22c. DATE SIGNED<br><b>01 Nov 83</b>                                                 |                                                                                                                                          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>L. HALL, LT, MC, USNR</b>                                                                                                                                                                                                                                                                                                                      |                                                                                                                                    | 22e. ADDRESS<br><b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,<br/>NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>                                                     |                                                                                    |                                                                                      |                                                                                                                                          |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                           | 23b. DATE<br><b>11-4-83</b>                                                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. JOSEPH</b>                                                                                                           |                                                                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>YONKERS, WESTCHESTER, N.Y.</b>      |                                                                                                                                          |
| 24. FUNERAL DIRECTOR<br><b>BRINSFIELD FUNERAL HOME, LEONARDTOWN, MARYLAND</b>                                                                                                                                                                                                                                                                                                              |                                                                                                                                    | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 7 1983</b><br>REGISTRAR'S SIGNATURE<br><i>John J. Carroll</i>                                                             |                                                                                    |                                                                                      |                                                                                                                                          |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



20% COLL

CHIEF



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                           |  |  |  |  |                                                                     |  |  |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|---------------------------------------------------------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                         |  |  |  |  | REG. NO.                                                            |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                               |  |  |  |  | 2a. DATE OF DEATH                                                   |  |  |  |  |
| FIRST MIDDLE LAST<br><i>Winnie Dixon Herdberg</i>                                                                                                                                                                                                                                                                                              |  |  |  |  | MONTH DAY YEAR<br><i>10 9 83</i>                                    |  |  |  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                         |  |  |  |  | 2b. HOUR                                                            |  |  |  |  |
| Female                                                                                                                                                                                                                                                                                                                                         |  |  |  |  | <i>10 P.M.</i>                                                      |  |  |  |  |
| 4. RACE                                                                                                                                                                                                                                                                                                                                        |  |  |  |  | 5. DATE OF BIRTH                                                    |  |  |  |  |
| Caucasian                                                                                                                                                                                                                                                                                                                                      |  |  |  |  | MONTH DAY YEAR<br><i>January 8, 1886</i>                            |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                      |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |  |  |  |
| Mississippi                                                                                                                                                                                                                                                                                                                                    |  |  |  |  | 97 YRS.                                                             |  |  |  |  |
| 7b. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                   |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |
| United States                                                                                                                                                                                                                                                                                                                                  |  |  |  |  | Montgomery MD.                                                      |  |  |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                      |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION             |  |  |  |  |
| Bethesda                                                                                                                                                                                                                                                                                                                                       |  |  |  |  | Suburban Hospital                                                   |  |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                                                                                                                                                                                                  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |  |
| Housewife                                                                                                                                                                                                                                                                                                                                      |  |  |  |  | home                                                                |  |  |  |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                     |  |  |  |  | 13b. INSIDE CITY LIMITS?                                            |  |  |  |  |
| Maryland                                                                                                                                                                                                                                                                                                                                       |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| 13c. CITY OR TOWN                                                                                                                                                                                                                                                                                                                              |  |  |  |  | 13d. STREET ADDRESS                                                 |  |  |  |  |
| Montgomery                                                                                                                                                                                                                                                                                                                                     |  |  |  |  | 4000 W. Underwood St 20815                                          |  |  |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                              |  |  |  |  | 15. MOTHER'S MAIDEN NAME                                            |  |  |  |  |
| FIRST MIDDLE LAST<br><i>Lindsey McDavitt Dixon</i>                                                                                                                                                                                                                                                                                             |  |  |  |  | FIRST MIDDLE LAST<br><i>Katie Jones</i>                             |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                              |  |  |  |  | 16b. SOCIAL SECURITY NO.                                            |  |  |  |  |
| No                                                                                                                                                                                                                                                                                                                                             |  |  |  |  | 426-07-7557-D                                                       |  |  |  |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                                                  |  |  |  |  | ADDRESS                                                             |  |  |  |  |
| Katherine H. Denny                                                                                                                                                                                                                                                                                                                             |  |  |  |  | 4000 W. Underwood Street, MD 20815                                  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>20 years</i>                                                            |  |  |  |  |                                                                     |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                             |  |  |  |  |                                                                     |  |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                         |  |  |  |  |                                                                     |  |  |  |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                               |  |  |  |  |                                                                     |  |  |  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                              |  |  |  |  |                                                                     |  |  |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                        |  |  |  |  |                                                                     |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                             |  |  |  |  |                                                                     |  |  |  |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                                                                                                                                                                                                                           |  |  |  |  |                                                                     |  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                                                                 |  |  |  |  |                                                                     |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                         |  |  |  |  |                                                                     |  |  |  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                            |  |  |  |  |                                                                     |  |  |  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                 |  |  |  |  |                                                                     |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July 73</i> to <i>October 83</i> , that (I) (we) lost saw the deceased alive on <i>October 9</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                                                                     |  |  |  |  |
| 22b. SIGNATURE <i>Dr. V. Russo MD</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                                                                                                                                        |  |  |  |  |                                                                     |  |  |  |  |
| 22c. DATE SIGNED <i>10/10/83</i>                                                                                                                                                                                                                                                                                                               |  |  |  |  |                                                                     |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John V. Russo, M.D.                                                                                                                                                                                                                                                                                      |  |  |  |  |                                                                     |  |  |  |  |
| 22e. ADDRESS 1145 19th Street, N.W. Washington, D.C. 20036                                                                                                                                                                                                                                                                                     |  |  |  |  |                                                                     |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>                                                                                                                                                                                                                                                                                     |  |  |  |  |                                                                     |  |  |  |  |
| 23b. DATE <i>October 11, 1983</i>                                                                                                                                                                                                                                                                                                              |  |  |  |  |                                                                     |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Metropolitan</i>                                                                                                                                                                                                                                                                                         |  |  |  |  |                                                                     |  |  |  |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Alexandria Virginia</i>                                                                                                                                                                                                                                                                             |  |  |  |  |                                                                     |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <i>Robert A. Pumphrey</i> ADDRESS <i>Funeral Homes, 7557 Wisconsin Ave. Bethesda MD</i>                                                                                                                                                                                                                              |  |  |  |  |                                                                     |  |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR <i>OCT 13 1983</i> REGISTRAR'S SIGNATURE <i>John J. Conner</i>                                                                                                                                                                                                                                                   |  |  |  |  |                                                                     |  |  |  |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

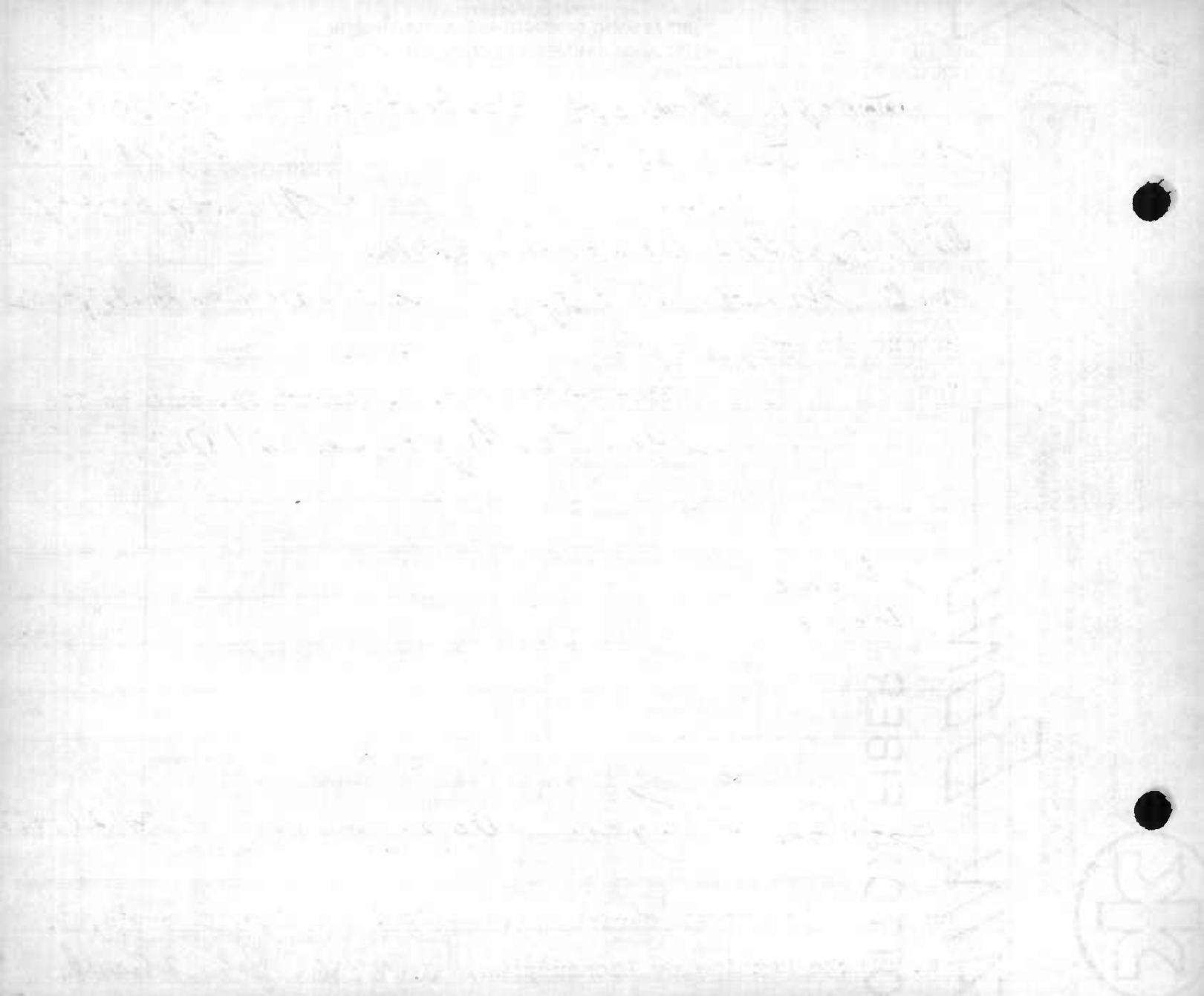
REG. NO.

|                                                                                                                                                                                                                                                                                                                               |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                |                                            |                                                                   |                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                  |                                                                                                           | 2a. DATE OF DEATH                                                                                                                                           |                                                                  | MONTH                                                                          | DAY                                        | YEAR                                                              | 2b. HOUR                                        |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                           |                                                                                                           | FIRST                                                                                                                                                       | MIDDLE                                                           | LAST                                                                           |                                            |                                                                   |                                                 |
| VIVIAN H. HEIDT MANN                                                                                                                                                                                                                                                                                                          |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                |                                            | 10-23-83 9:25 AM                                                  |                                                 |
| 3. SEX                                                                                                                                                                                                                                                                                                                        | 4. RACE                                                                                                   | 5. DATE OF BIRTH                                                                                                                                            |                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                |                                            | 7. IF UNDER 1 YEAR                                                |                                                 |
| Female                                                                                                                                                                                                                                                                                                                        | White                                                                                                     | MONTH DAY YEAR<br>April 24, 1905                                                                                                                            |                                                                  | 78 YRS.                                                                        |                                            | IF UNDER 24 HRS                                                   |                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                     | 7b. CITIZEN OF WHAT COUNTRY?                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                           |                                            |                                                                   |                                                 |
| New York                                                                                                                                                                                                                                                                                                                      | U.S.A.                                                                                                    |                                                                                                                                                             |                                                                  | Montgomery Co., MD.                                                            |                                            |                                                                   |                                                 |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY          |                                                                   |                                                 |
| Gaithersburg                                                                                                                                                                                                                                                                                                                  | Wilson Health Care Center                                                                                 |                                                                                                                                                             | Housewife                                                        |                                                                                |                                            |                                                                   |                                                 |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                  |                                                                                                           | 13b. COUNTY                                                                                                                                                 | 13c. CITY OR TOWN                                                | 13d. INSIDE CITY LIMITS?                                                       |                                            | 13e. STREET ADDRESS                                               |                                                 |
| Maryland                                                                                                                                                                                                                                                                                                                      |                                                                                                           | Montgomery                                                                                                                                                  | Germantown                                                       | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                            | 20400 Frederick Rd. 20874                                         |                                                 |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                             |                                                                                                           | 15. MOTHER'S MAIDEN NAME                                                                                                                                    |                                                                  |                                                                                |                                            |                                                                   |                                                 |
| FIRST MIDDLE LAST<br>Louis A. Hults                                                                                                                                                                                                                                                                                           |                                                                                                           | FIRST MIDDLE LAST<br>Mary Emma Douglas                                                                                                                      |                                                                  |                                                                                |                                            |                                                                   |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                                              |                                                                                                           | 16b. SOCIAL SECURITY NO.                                                                                                                                    |                                                                  | 17. INFORMANT ADDRESS                                                          |                                            |                                                                   |                                                 |
| No                                                                                                                                                                                                                                                                                                                            |                                                                                                           | 077-09-2152D                                                                                                                                                |                                                                  | 304 E. 90th St. # 5D<br>Jane H. McDonald, New York, N.Y. 10128                 |                                            |                                                                   |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                |                                            |                                                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Cerebral thrombosis                                                                                                                                                                                                                                                                                       |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                |                                            |                                                                   | 3 days                                          |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                |                                            |                                                                   | 4 years                                         |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                |                                            |                                                                   |                                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>Chronic brain syndrome, Rheumatoid arthritis                                                                                                                                          |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                |                                            |                                                                   |                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                        |                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                  | 20a. AUTOPSY?                                                                  |                                            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |                                                 |
|                                                                                                                                                                                                                                                                                                                               |                                                                                                           |                                                                                                                                                             |                                                                  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                            | YES <input type="checkbox"/> NO <input type="checkbox"/>          |                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                      |                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                            |                                                                   |                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                  |                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                            |                                                                   |                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 12, 19 75, to Oct 23, 19 83, that (I) (we) lost<br>saw the deceased alive on Oct 18, 19 83, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |                                                                                                           | 22b. SIGNATURE<br>DEGREE                                                                                                                                    |                                                                  | 22c. DATE SIGNED                                                               |                                            |                                                                   |                                                 |
| James R. Moore Jr.                                                                                                                                                                                                                                                                                                            |                                                                                                           | MD                                                                                                                                                          |                                                                  | 10-23-83                                                                       |                                            |                                                                   |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                  |                                                                                                           | 23b. DATE                                                                                                                                                   | 23c. NAME OF CEMETERY OR CREMATORY                               |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |                                                                   |                                                 |
| Burial                                                                                                                                                                                                                                                                                                                        |                                                                                                           | Oct. 26, 1983                                                                                                                                               | Mount Olivet                                                     |                                                                                | Frederick, Frederick, Md.                  |                                                                   |                                                 |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                  |                                                                                                           | 25a. DATE REC'D. BY REGISTRAR                                                                                                                               |                                                                  | 25b. REGISTRAR'S SIGNATURE                                                     |                                            |                                                                   |                                                 |
| Olin L. Molesworth, P.A., Damascus, Md.                                                                                                                                                                                                                                                                                       |                                                                                                           | OCT 26 1983                                                                                                                                                 |                                                                  | John J. Gough                                                                  |                                            |                                                                   |                                                 |

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|                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                     |  |                                                                                                            |  |                                                                           |  |                                                                                                                                                             |  |                                           |  |                                                                                     |  |                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------|--|------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------|--|-------------------------------------------------------------------------------------|--|------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Joseph Robert Herbert Sr.</b>                                                                                                                                                                                                                                                                                                                                                               |  |                     |  |                                                                                                            |  | 20. DATE KNOWN OF DEATH ESTIMATED<br>MONTH DAY YEAR<br><b>Oct 20 1983</b> |  |                                                                                                                                                             |  |                                           |  | 26. HOUR MIN.<br><b>7:18</b>                                                        |  |                              |  |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br><b>W</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan 11 1951</b>                                                   |  | 6. AGE IN YEARS<br>(LAST BIRTHDAY)<br>YEARS MONTHS DAYS<br><b>32 RS.</b>  |  | IF UNDER 1 YR.<br>MONTHS DAYS<br><b></b>                                                                                                                    |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b></b> |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>Oct 20 1983</b>                    |  | 26. HOUR MIN.<br><b>7:18</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                     |  | 7b. CITIZEN OR WHAT COUNTRY?<br><b>U.S.A.</b>                                                              |  |                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |                                           |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery MD</b>                        |  |                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>P.O. Box 312 Dorem Ave Apt. 102</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                           |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                               |  |                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                   |  |                              |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                            |  |                     |  | 13a. STATE<br><b>MD</b>                                                                                    |  |                                                                           |  | 13b. COUNTY<br><b>Mont.</b>                                                                                                                                 |  |                                           |  | 13c. CITY OR TOWN<br><b>P.O. Box 312</b>                                            |  |                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Hubert Robert Herbert</b>                                                                                                                                                                                                                                                                                                                                                                |  |                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nettie Guy</b>                                         |  |                                                                           |  |                                                                                                                                                             |  |                                           |  |                                                                                     |  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                          |  |                     |  | 16b. SOCIAL SECURITY NO.<br><b>213-22-1432</b>                                                             |  |                                                                           |  | 17. INFORMANT<br><b>Jos. R. Herbert Jr. same as 13c</b>                                                                                                     |  |                                           |  | ADDRESS                                                                             |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sudden Myocardial Dis.</b><br>4291<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                              |  |                     |  |                                                                                                            |  |                                                                           |  |                                                                                                                                                             |  |                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                        |  |                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1<br><b>None</b>                                                                                                                                                                                                                                                                                         |  |                     |  |                                                                                                            |  |                                                                           |  |                                                                                                                                                             |  |                                           |  |                                                                                     |  |                              |  |
| 19a. DATE OF OPERATION<br><b>None</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  |                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                          |  |                                                                           |  |                                                                                                                                                             |  |                                           |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                              |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                   |  |                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                 |  |                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)                                                                               |  |                                           |  |                                                                                     |  |                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                             |  |                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                |  |                                                                           |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                           |  |                                                                                     |  |                              |  |
| 22. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                     |  |                                                                                                            |  |                                                                           |  |                                                                                                                                                             |  |                                           |  |                                                                                     |  |                              |  |
| ACTUAL SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                     |  | TITLE (SPECIFY)<br><b>Dap</b>                                                                              |  |                                                                           |  | MEDICAL EXAMINER<br><b>[Signature]</b>                                                                                                                      |  |                                           |  | DATE SIGNED<br><b>Oct 26 1983</b>                                                   |  |                              |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>W. Clarke Mattingley Leonardtown, Md.</b>                                                                                                                                                                                                                                                                                                                                                       |  |                     |  |                                                                                                            |  |                                                                           |  |                                                                                                                                                             |  |                                           |  |                                                                                     |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                     |  | 23b. DATE<br><b>10/22/83</b>                                                                               |  |                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Christ Episcopal Cem.</b>                                                                                          |  |                                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Chaptico, St Mary's, Md.</b>       |  |                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>W. Clarke Mattingley Leonardtown, Md.</b>                                                                                                                                                                                                                                                                                                                                                          |  |                     |  | ADDRESS<br><b>25 1983</b>                                                                                  |  |                                                                           |  | 25a. DATE REC'D. BY REGISTRAR<br><b>John J. Connel</b>                                                                                                      |  |                                           |  | 25b. REGISTRAR'S SIGNATURE                                                          |  |                              |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 7 0 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                               |                                                                                           |                                            |                                                                                                                            |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Antonia Florencia Hidalgo</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 2 83</b>                  |                                                                                                                                                             |                                                                                               | 2b. HOUR<br><b>2 29</b> M                                                                 |                                            |                                                                                                                            |  |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br><b>Spanish</b>                                                                                                          |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 29 03</b>                                                                                                        |                                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.                                         |                                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 4 HRS.<br>HOURS MIN.                                                            |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Cuba</b>                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Cuba</b>                                                                                        |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b>                      |                                            |                                                                                                                            |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park Washington</b>                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Adventist Hosp</b> |                                                                        |                                                                                                                                                             |                                                                                               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker Ret.</b> |                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>                                                                        |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY CITY OR TOWN<br><b>Maryland Prince George's Adelphi</b>                                                                                                                                                                                                                  |  |                                                                                                                                    |                                                                        | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |                                                                                               | 13c. STREET ADDRESS<br><b>1801 Metzger Rd.</b>                                            |                                            |                                                                                                                            |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Aurelio Huerta</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                    |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ernestina Sosa</b>                                                                                      |                                                                                               |                                                                                           |                                            |                                                                                                                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Unknown None</b>                                                                                                                                                                                                                                                               |  |                                                                                                                                    |                                                                        | 16b. SOCIAL SECURITY NO.<br><b>577-86-4179</b>                                                                                                              |                                                                                               | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Olga H. Llerena, Dtr / . Wash/DC. 2000</b>            |                                            |                                                                                                                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Insufficiency</b><br>4310<br>DUE TO, OR AS CONSEQUENCE OF:<br>(b) <b>Septic, aspiration pneumonia</b><br>DUE TO, OR AS CONSEQUENCE OF:<br>(c) <b>Cerebral hemorrhage, dehydration</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                               |                                                                                           |                                            |                                                                                                                            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                   |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                               |                                                                                           |                                            |                                                                                                                            |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                              |  |                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |                                                                                                                                                             |                                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)            |                                            |                                                                                                                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                        |  |                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                                               | 21f. LOCATION<br>(STREET) CITY OR TOWN COUNTY STATE                                       |                                            |                                                                                                                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/2/83</b> 19 to <b>10/2/83</b> 19, that (I) (we) last saw the deceased alive on <b>10/2/83</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                   |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                               |                                                                                           |                                            |                                                                                                                            |  |  |
| 22b. SIGNATURE<br><b>Miguel A. Rodriguez M.D.</b><br>DEGREE<br>22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MIGUEL A. RODRIGUEZ</b>                                                                                                                                                                                                                                                    |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                               | 22c. DATE SIGNED<br><b>10/3/83</b>                                                        |                                            | 22d. ADDRESS<br><b>831 University Blvd. S. Spring, Md.</b>                                                                 |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    | 23b. DATE<br><b>Oct. 5, 1983</b>                                       |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cemetery Silver Spring, Mont. Md.</b> |                                                                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |                                                                                                                            |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>W.W. CHAMBERS CO, 8655 Ga. Ave., SS, Md. 20007</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                               | 25a. DATE REC'D. BY REGISTRAR<br><b>4 1983</b>                                            |                                            | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Gough</b>                                                                         |  |  |

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                  |  |                                                                                                                                               |  | 8 3 2 7 7 1 0<br>REG. NO.                                                                                        |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>RUBY H. HINES</u>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                               |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>10-13-83</u>                                                              |  |
| 3. SEX<br><u>Female</u>                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br><u>Caucasian</u>                                                                                                                   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><u>Nov. 3, 1891</u>                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Tennessee</u>                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                                 |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>91</u> YRS                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><u>Kensington</u>                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Circle Manor Nursing Home</u> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Montgomery</u> MD.                                                    |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Librarian</u>                                                                                                                                                                                                                                                                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>U.S. Gov't</u>                                                                                        |  |                                                                                                                  |  |
| 13a. STATE<br><u>Maryland</u>                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY<br><u>Montgomery</u>                                                                                                              |  | 13c. CITY OR TOWN<br><u>Silver Spring</u>                                                                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Charles D. Hicks</u>                                                                                                                                                                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Mary Ida Noblett</u>                                                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>NO</u>                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br><u>578-03-2809</u>                                                                                                |  | 17. INFORMANT<br>NAME ADDRESS<br><u>Ruby H. Sullivan = Daughter 1930 Plyers Mill Rd, Silver Spring, Md 20902</u> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>SEPTICEMIA</u><br><u>2639</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>SENILE INANITION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>ONE WEEK</u><br><u>MONTHS</u> |  |                                                                                                                                               |  |                                                                                                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>CEREBROVASCULAR INSUFFICIENCY WITH DEMENTIA</u>                                                                                                                                                                            |  |                                                                                                                                               |  |                                                                                                                  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                              |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                |  |
| 22a. I certify that (1) (his hospital) attended the deceased from <u>March 15, 1982</u> to <u>Oct 5, 1983</u> , that (1) (we) last saw the deceased alive on <u>Oct 5, 1983</u> , and that (1) (my) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.                                 |  |                                                                                                                                               |  |                                                                                                                  |  |
| 22b. SIGNATURE<br><u>Martin C. Shargel</u><br>DEGREE<br><u>M.D.</u>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                               |  | 22c. DATE SIGNED<br><u>October 13, 1983</u>                                                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>MARTIN C. SHARGEL</u>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                               |  | 22e. ADDRESS<br><u>3720 FARFA GATE RD KENNINGTON, MARYLAND 20895</u>                                             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><u>10/15/83</u>                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Cemetery</u>                                                 |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Suitland Pr. Geo. Maryland</u>                                                                                                                                                                                                                                                                                       |  | 24. FUNERAL DIRECTOR<br>NAME<br><u>FRANCIS J. COLLINS</u>                                                                                     |  | 25a. DATE REC'D. BY REGISTRAR<br><u>OCT 14 1983</u>                                                              |  |
| 500 UNIVERSITY BLVD. W., SILVER SPRING, MD. 20901                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Collins</u>                                                             |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                  |  |                          |  | 8 3 2 7 7 1 1                  |     |         |          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|--------------------------|--|--------------------------------|-----|---------|----------|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                             |  | REG. NO.                                                                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                  |  |                          |  |                                |     |         |          |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                      |  | FIRST                                                                                                                                                                                                    |  | MIDDLE                                                                                                                                                      |  | LAST                                                                             |  | 2a. DATE OF DEATH        |  | MONTH                          | DAY | YEAR    | 2b. HOUR |
| EMMA                                                                                                                                                                                                                                                                                                                                                                     |  | HIXEN                                                                                                                                                                                                    |  | BAUGHT                                                                                                                                                      |  |                                                                                  |  | 10-14-83                 |  |                                |     | 9:40 AM |          |
| SEX                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE                                                                                                                                                                                                  |  | 5. DATE OF BIRTH                                                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                  |  | IF UNDER 1 YEAR          |  | IF UNDER 24 HRS                |     |         |          |
| FEMALE                                                                                                                                                                                                                                                                                                                                                                   |  | WHITE                                                                                                                                                                                                    |  | JULY 4, 1901                                                                                                                                                |  | 82                                                                               |  | MONTHS                   |  | DAYS                           |     | HOURS   |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                             |  |                          |  |                                |     |         |          |
| PENNSYLVANIA                                                                                                                                                                                                                                                                                                                                                             |  | U.S.A.                                                                                                                                                                                                   |  |                                                                                                                                                             |  | MONTGOMERY                                                                       |  |                          |  |                                |     | MD.     |          |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                                                                                |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                |  |                          |  |                                |     |         |          |
| GAITHERSBURG                                                                                                                                                                                                                                                                                                                                                             |  | 19121 RHODES WAY                                                                                                                                                                                         |  | SEAMSTRESS                                                                                                                                                  |  | CLOTHING CO.                                                                     |  |                          |  |                                |     |         |          |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                  |  | 13a. STATE                                                                                                                                                                                               |  | 13b. COUNTY                                                                                                                                                 |  | 13c. CITY OR TOWN                                                                |  | 13d. INSIDE CITY LIMITS? |  | 13e. STREET ADDRESS / ZIP CODE |     |         |          |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                 |  | MONTGOMERY                                                                                                                                                                                               |  | GAITHERSBURG                                                                                                                                                |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>              |  | 19121 RHODES WAY         |  | 20879                          |     |         |          |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME                                                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                  |  |                          |  |                                |     |         |          |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                        |  | FIRST MIDDLE LAST                                                                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                  |  |                          |  |                                |     |         |          |
| FREDERICK                                                                                                                                                                                                                                                                                                                                                                |  | TOBER                                                                                                                                                                                                    |  | HOLDA                                                                                                                                                       |  | POHL                                                                             |  |                          |  |                                |     |         |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.                                                                                                                                                                                 |  | 17. INFORMANT                                                                                                                                               |  | ADDRESS                                                                          |  |                          |  |                                |     |         |          |
| NO                                                                                                                                                                                                                                                                                                                                                                       |  | 271-10-3053A                                                                                                                                                                                             |  | CHARLOTTE LANTZ, NEICE                                                                                                                                      |  | 19121 RHODES WAY                                                                 |  |                          |  |                                |     |         |          |
|                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                          |  |                                                                                                                                                             |  | GAITHERSBURG, MD.                                                                |  | 20879                    |  |                                |     |         |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u><br>2030<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                                           |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>years                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                  |  |                          |  |                                |     |         |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                  |  |                          |  |                                |     |         |          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                         |  | 20a. AUTOPSY?                                                                                                                                               |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?                |  |                          |  |                                |     |         |          |
|                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                          |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                         |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                         |  |                          |  |                                |     |         |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                  |  |                          |  |                                |     |         |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                  |  |                          |  |                                |     |         |          |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>2/17</u> , 19 <u>82</u> , to <u>10/14</u> , 19 <u>83</u> , that (I) (we) lost<br>saw the deceased alive on <u>9/23</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><u>Steven Newman</u><br>DEGREE <u>MD</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>10/14/83</u>                                                                                                                         |  |                                                                                  |  |                          |  |                                |     |         |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                    |  | 22e. ADDRESS                                                                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                  |  |                          |  |                                |     |         |          |
| STEVEN NEWMAN M.D.                                                                                                                                                                                                                                                                                                                                                       |  | 19261 MONTGOMERY VILLAGE AVE. GAITHERSBURG                                                                                                                                                               |  |                                                                                                                                                             |  |                                                                                  |  |                          |  |                                |     |         |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <u>BURIAL</u>                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><u>10/22/83</u>                                                                                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>KNOLLWOOD CEMETERY</u>                                                                                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>MAYFIELD HGTS CUYAHOGA OHIO</u> |  |                          |  |                                |     |         |          |
| 24. FUNERAL DIRECTOR<br>NAME <u>RICHARD RAPP, INC</u><br>ADDRESS <u>1120 CONN AVE., N.W. # 940 WASHINGTON, D.C. 20036</u>                                                                                                                                                                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR<br><u>OCT 19 1983</u>                                                                                                                                                      |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                                                                                            |  |                                                                                  |  |                          |  |                                |     |         |          |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 27712

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                             |                                                         |                                                                                                   |                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>GEORGE LEE HOFFMAN                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCTOBER 28, 1983 |                                                                                                   | 2b. HOUR<br>3:15 <sup>P</sup> <sub>M</sub> |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>WHITE                                                                                                                                            |                                                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JAN 25, 1924                                                |                                            |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.                                                                                                                                                                                                                                                                                                                                                             |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                         | 8. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY COUNTY MD.                                     |                                            |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WYOMING                                                                                                                                                                                                                                                                                                                                                    |  | 10. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                         |                                                         | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY COUNTY MD.                                    |                                            |  |
| 12. CITY OR TOWN OF DEATH<br>BETHESDA                                                                                                                                                                                                                                                                                                                                                                  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE CLINICAL CENTER, NIH                       |                                                         | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>DIRECTOR - PUBLIC WORKS - GOVT |                                            |  |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>15a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                  |  | 15b. CITY OR TOWN<br>A.A. SEVERNA PK                                                                                                                        |                                                         | 15c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                            |  |
| 16. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE HOFFMAN                                                                                                                                                                                                                                                                                                                                               |  | 17. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LUL MILLS                                                                                                  |                                                         | 18. STREET ADDRESS<br>313 FERNWOOD DR 21146                                                       |                                            |  |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br>WW II                                                                                                                                                                                                                                                                                                                    |  | 20. SOCIAL SECURITY NO.<br>262247825                                                                                                                        |                                                         | 21. INFORMANT<br>ADDRESS<br>MRS. EVELYN HOFFMAN (WIFE) SAME AS ABOVE                              |                                            |  |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4149 IMMEDIATE CAUSE (a) Status-post three-vessel coronary artery disease by-pass surgery<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                                                                             |                                                         |                                                                                                   |                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.                                                                                                                                                                                                                                                                      |  |                                                                                                                                                             |                                                         |                                                                                                   |                                            |  |
| 23a. DATE OF OPERATION<br>10/26/83                                                                                                                                                                                                                                                                                                                                                                     |  | 23b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Disease coronary arteries                                                                               |                                                         | 23c. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>              |                                            |  |
| 24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                   |  | 24b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                         | 24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                    |                                            |  |
| 25a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                           |  | 25b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                         | 25c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                 |                                            |  |
| 26. I certify that (X) (this hospital) attended the deceased from October 23, 1983, to October 28, 1983, that X (we) lost<br>saw the deceased alive on above X (we) (did) (did not) view the body after death.                                                                                                                                                                                         |  |                                                                                                                                                             |                                                         |                                                                                                   |                                            |  |
| 27a. SIGNATURE<br>Jose Montalvo MD                                                                                                                                                                                                                                                                                                                                                                     |  | 27b. DEGREE<br>MD                                                                                                                                           |                                                         | 27c. DATE SIGNED<br>10-29-83                                                                      |                                            |  |
| 28a. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jose Montalvo MD                                                                                                                                                                                                                                                                                                                                              |  | 28b. ADDRESS<br>NATIONAL INSTITUTES OF HEALTH<br>CLINICAL CENTER, BETHESDA, MD. 20205                                                                       |                                                         |                                                                                                   |                                            |  |
| 29a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                 |  | 29b. DATE<br>11-1-83                                                                                                                                        |                                                         | 29c. NAME OF CEMETERY OR CREMATORY<br>ARLINGTON NAT'L                                             |                                            |  |
| 30a. FUNERAL DIRECTOR<br>NAME<br>Edouard S. Baranov                                                                                                                                                                                                                                                                                                                                                    |  | 30b. ADDRESS<br>Severna Pk                                                                                                                                  |                                                         | 30c. DATE REC'D. BY REGISTRAR<br>NOV 04 1983                                                      |                                            |  |
| 31a. REGISTRAR'S SIGNATURE<br>Ben J. Conner                                                                                                                                                                                                                                                                                                                                                            |  | 31b. REGISTRAR'S SIGNATURE                                                                                                                                  |                                                         |                                                                                                   |                                            |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                           |  | 8 3 2 7 7 1 3                                                                                                                                               |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1- FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                           |  | REG. NO.                                                                                                                                                    |  |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Julius Francis Holbrook</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                           |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 11, 1983</b>                                                                                              |  | 2b. HOUR<br>P. M.<br><b>3:15</b>                                                                                           |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br><b>White</b>                                                                                                                   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Febr. 12, 1890</b>                                                                                                 |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b> YRS.                                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2835 Shanandale Drive</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Attorney</b>                                                                         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov't</b>                                                                     |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY<br><b>Montgomery</b>                                                                                                          |  | 13c. CITY OR TOWN<br><b>Sil. Spring</b>                                                                                                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Holubovic</b>                                                                                                                                                                                                                                                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Illena Was</b>                                                                        |  | 13e. STREET ADDRESS<br><b>2835 Shanandale Drive</b>                                                                                                         |  | 20904                                                                                                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br><b>247-78-1863</b>                                                                                            |  | 17. INFORMANT<br><b>Louise C. Holbrook (Same as #13 above)</b>                                                                                              |  | ADDRESS                                                                                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Cardio-vascular Dis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Yes.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 Years</b>                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>None</b>                                                                                                                                                                                                                                                                                |  |                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                                                     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>Dec. 22, 19 81</b> , to <b>Oct. 11, 19 83</b> , that (I) (we) last saw the deceased alive on <b>Aug. 13, 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                          |  |                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Eino Magi M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | DEGREE<br><b>Attending Medical</b>                                                                                                        |  | STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>                                    |  | 22c. DATE SIGNED<br><b>10/11/1983</b>                                                                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Eino Magi</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 22e. ADDRESS<br><b>11120 N. Hamp. Ave, Sil. Spr, Md</b>                                                                                   |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><b>10/14/83</b>                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Old St. Andrews Par. Charleston, So. Carolina</b>                                                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>20904</b>                                                                 |  |
| 24. FUNERAL DIRECTOR<br><b>Takoma Fun'l Home, Inc</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 25. ADDRESS<br><b>254 Carroll St N.W., Wash, D.C.</b>                                                                                     |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 17 1983</b>                                                                                                         |  | REGISTRAR'S SIGNATURE<br><b>Joan J. Gough</b>                                                                              |  |

BP



CONFIDENTIAL



10/11/83 10/11/83 10/11/83  
1120 N. Main Ave. 111 Sp. 111  
20904  
10/11/83 10/11/83 10/11/83  
1120 N. Main Ave. 111 Sp. 111  
20904  
10/11/83 10/11/83 10/11/83  
1120 N. Main Ave. 111 Sp. 111  
20904

Anterolateralis Cerebro-vascular Dis. 193.  
Congestive Heart Failure 10 Years

No. 11 547-75-1003 Louise C. Highrock (Same as 413 above)

Joseph Holobavio Ellen Kae  
Maryland Montgomery 311 Spring xx 2093 Shannale Drive  
Silver Spring 2093 Shannale Drive Attorney U.S. Gov't

Tennessee U. S. A. Montgomery  
White 2093 22 1830 22

Julius Francis Highrock October 11, 1983 2:15 p

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                  |  |                                                                                                 | REG. NO.                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                  |  |                                                                                                 | 2a. DATE OF DEATH MONTH DAY YEAR             |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>Maryolive S. Holcer                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                  |  |                                                                                                 | 2b. HOUR<br>12:22 PM                         |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br>CAUC.                                                                                                                 |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5-27-13                                                      |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENN.                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.                                                      |                                              |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                                   |                                              |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY<br>MONT.                                                                                                             |  | 13c. CITY OR TOWN<br>SIL. SPG.                                                                  |                                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>NORMAN                                                                                                                                                                                                                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>OLIVE                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.<br>577-01-5417                                                                                          |  | 17. INFORMANT ADDRESS<br>RICHARD J. HOLCER SAME 13c                                             |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>5860<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Kidney failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                  |  |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.                                                                                                                                                                                                                                                            |  |                                                                                                                                  |  |                                                                                                 |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |                                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> OR NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                              |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-8, 1983, to 10-11, 1983, that (I) (we) last saw the deceased alive on 10-10, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                             |  |                                                                                                                                  |  |                                                                                                 |                                              |  |
| 22b. SIGNATURE<br>Edward J. Richards M.D.                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                  |  | 22c. DATE SIGNED<br>10-11-83                                                                    |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>EDWARD J. RICHARDS M.D.                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                  |  | 22e. ADDRESS<br>10301 GEORGIA AVE. SIL. SPG. MD. 20902                                          |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>CREMATION                                                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br>OCT. 13, 1983                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br>METROPOLITAN CREMATORY ALEXANDRIA ALEXANDRIA VA           |                                              |  |
| 24. FUNERAL DIRECTOR NAME<br>FRANCIS J. COLLINS                                                                                                                                                                                                                                                                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1983                                                                                     |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Gough                                                     |                                              |  |

FRANCIS J. COLLINS  
 211. STG. NO. 20901  
 500 UNIV. BLDG. W.  
 OCT. 12, 1962 METRO  
 POLITAN CREATORIA ALEXANDRIA VA  
 10501 GEORGIA AVE. 211. STG. NO. 20902



CHIEF  
 10501 GEORGIA AVE. 211. STG. NO. 20902

575-01-2413 RICHARD J. HOLCOMB 211. STG. NO. 20901  
 SCHWELTZ CLINT  
 10501 GEORGIA AVE. 211. STG. NO. 20902

CAUC.

TECH.

10501 GEORGIA AVE. 211. STG. NO. 20902

## Medical Examiners Office Notified (Dr. Rayle)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| FOR Item part 2 & 21a thru 22a                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                       |  | STATE OF MARYLAND                                                                                                                                           |  |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. STATE REGISTRAR film 585 11-10-83 cn                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                       |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                     |  |                                                                                                                            |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                       |  | REG. NO. 83 27715                                                                                                                                           |  |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Edna VIRGINIA Holland</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                       |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10-5-83</b>                                                                                                       |  |                                                                                                                            |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br><b>White</b>                                                                                                               |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 18, 1907</b>                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>76</b>                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b>                                                                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Elect. Const. Co.</b>                                                              |  |
| 13a. STATE<br><b>Md. 20815</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY<br><b>Montgomery</b>                                                                                                      |  | 13c. CITY OR TOWN<br><b>Chevy Chase</b>                                                                                                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Richard B. Shreve</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Florence -- Price</b>                                                             |  | 13e. STREET ADDRESS<br><b>3504 Hamlet Place</b>                                                                                                             |  | 20815                                                                                                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br><b>578-05-4780</b>                                                                                        |  | 17. INFORMANT<br>ADDRESS<br><b>Beverly H. Polant, 10944 Wickshire Way, Rockville, Md. 20852</b>                                                             |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Anoxic Encephalopathy</b><br><b>5191</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cardio pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Tracheal obstruction from aspirated food</b> |  |                                                                                                                                       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hr</b><br><b>24 hr</b><br><b>24 hr</b>                                                                |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Meat was removed from the trachea at time of CPR</b>                                                                                                                                                                                                                                                     |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>7 P.M. 10-4-83</b>                                                              |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>Eating dinner</b>                                                   |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>Home</b>                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3504 Hamlet Pl. Chevy Chase Md 20815</b>                                                            |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/5/83</b> to <b>10/5/83</b> , that (I) (we) lost saw the deceased alive on <b>10/5/83</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.<br><b>Natural As a result of item 18</b>                                                                                   |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Robert H Blee MD</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       |  | DEGREE<br><b>MD</b>                                                                                                                                         |  | 22c. DATE SIGNED<br><b>10/5/83</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert H Blee MD</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                       |  | 22e. ADDRESS<br><b>8218 Wisconsin Ave, Bethesda 20814</b>                                                                                                   |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>10/8/83</b>                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Memorial Park</b>                                                                                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rockville, Maryland</b>                                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., NW, Washington, D.C. 20016</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 11 1983</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                                                        |  |

100% Cotton



100% COTTON

100% COTTON

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100% COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, though it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.


 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

83 27716

REG. NO.

|                                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                          |                                                                     |                               |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                     |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR                      |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                           |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR                      |                                              |
| ANNIE                                                                                                                                                                                                                                                                                                      |                                                                                                        | 10-30-83                                                                                                                                                 |                                                                     | 4:23PM                        |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                     | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 7. IF UNDER 1 YEAR            |                                              |
| Female                                                                                                                                                                                                                                                                                                     | White                                                                                                  | 07-15-01                                                                                                                                                 | 82 YRS.                                                             | IF UNDER 24 HRS.              |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                               |                                              |
| Russia                                                                                                                                                                                                                                                                                                     | USA                                                                                                    | Montgomery                                                                                                                                               | MD.                                                                 |                               |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                               |                                              |
| ROCKVILLE                                                                                                                                                                                                                                                                                                  | COLLINGSWOOD NURSING HOME                                                                              | HOMEMAKER                                                                                                                                                | HOME                                                                |                               |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                 | 13b. COUNTY                                                                                            | 13c. CITY OR TOWN                                                                                                                                        | 13d. INSIDE CITY LIMITS?                                            | 13e. STREET ADDRESS           |                                              |
| MD.                                                                                                                                                                                                                                                                                                        | MONTGOMERY                                                                                             | ROCKVILLE                                                                                                                                                | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 299 HURLEY AVE. (20852)       |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                          | 15. MOTHER'S MAIDEN NAME                                                                               | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                             |                                                                     |                               |                                              |
| LEONARD                                                                                                                                                                                                                                                                                                    | SHIRLEY                                                                                                | NO NONE 099-01-8857                                                                                                                                      |                                                                     |                               |                                              |
| 17. INFORMANT                                                                                                                                                                                                                                                                                              |                                                                                                        | ADDRESS                                                                                                                                                  |                                                                     |                               |                                              |
| LEONARD HOLLANDER                                                                                                                                                                                                                                                                                          |                                                                                                        | 13200 GEORGIA AVE. SILVER SPRING, MD                                                                                                                     |                                                                     |                               |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          |                                                                     |                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                                     |                               | Several Years                                |
| 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Stroke - several years duration-Semicomotose                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          |                                                                     |                               |                                              |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                          |                                                                     |                               |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                           |                                                                                                        |                                                                                                                                                          |                                                                     |                               |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       | 20a. AUTOPSY?                                                                                                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                               |                                              |
|                                                                                                                                                                                                                                                                                                            |                                                                                                        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                               |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |                                                                     |                               |                                              |
|                                                                                                                                                                                                                                                                                                            | P.M. 19                                                                                                |                                                                                                                                                          |                                                                     |                               |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME NOT WHILE <input type="checkbox"/> AT HOME                                                                                                                                                                                                     | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                     |                               |                                              |
|                                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                          |                                                                     |                               |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/30/83 to 10/30/83, that (I) (we) lost saw the deceased alive on 8/30/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sign the certificate of death. |                                                                                                        |                                                                                                                                                          |                                                                     |                               |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                             |                                                                                                        | DEGREE                                                                                                                                                   |                                                                     | 22c. DATE SIGNED              |                                              |
| MYRON L. LENKIN                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                          |                                                                     | 10/31/83                      |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                      |                                                                                                        | 22e. ADDRESS                                                                                                                                             |                                                                     | 22f. DATE REC'D. BY REGISTRAR |                                              |
| MYRON L. LENKIN                                                                                                                                                                                                                                                                                            |                                                                                                        | 2309 SHOREFIELD RD WHEATON, MD                                                                                                                           |                                                                     | NOV 03 1983                   |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                  | 23b. DATE                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |                               |                                              |
| BURIAL                                                                                                                                                                                                                                                                                                     | 11-1-83                                                                                                | MONTEFIORE CEM.                                                                                                                                          | QUEENS, NEW YORK                                                    |                               |                                              |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                       |                                                                                                        | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |                                                                     | 25b. REGISTRAR'S SIGNATURE    |                                              |
| 1170 ROCKVILLE PK. ROCKVILLE MD.....                                                                                                                                                                                                                                                                       |                                                                                                        | NOV 03 1983                                                                                                                                              |                                                                     | John J. Connel                |                                              |
| DANZANSKY-GOLDBERG MEM CHP.                                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                          |                                                                     |                               |                                              |

MEDICAL CERTIFICATION



Handwritten notes in the bottom left corner, including the word "Village" and some illegible scribbles.

Handwritten notes in the bottom right corner, including the word "Village" and some illegible scribbles.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND-21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

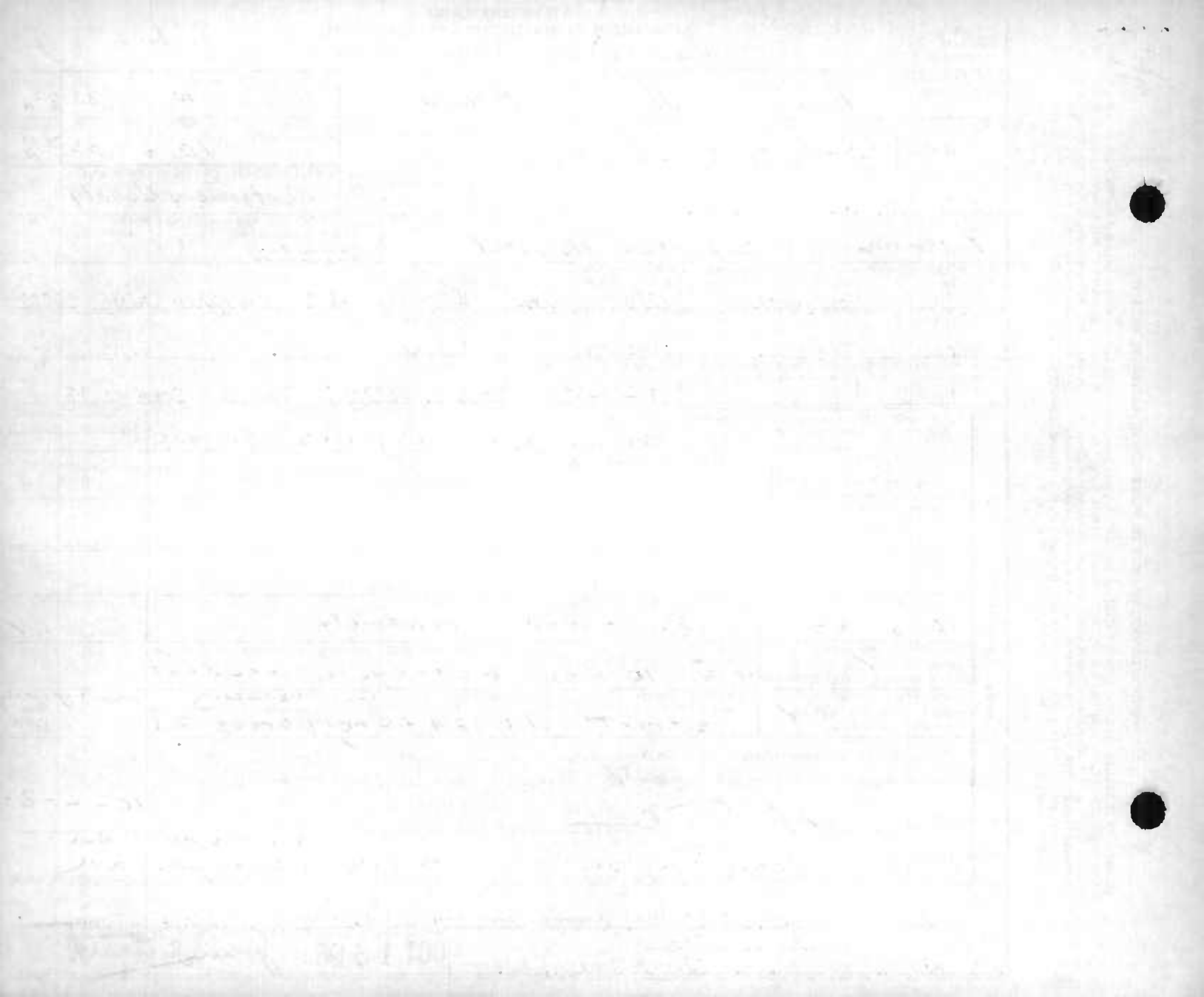
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                        |                                                                                     |                                                                                                                                                          |                                                                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ross W. Holland</b>                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                        | 2a. DATE KNOWN OF DEATH<br>MONTH <input checked="" type="checkbox"/> DAY 10 YEAR 83 |                                                                                                                                                          | 2b. HOUR<br>8 <sup>10</sup> A M                                                          |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                  | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH 7 DAY 5 YEAR 63                                                                                              | 6. AGE (IN YEARS)<br>20 YRS.                                                        | IF UNDER 1 YR.<br>MONTHS _____ DAYS _____                                                                                                                | IF UNDER 24 HRS.<br>HOURS _____ MIN. _____                                               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, D.C.</b>                                                                                                                                                                                                                                                                                                                                                                   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                          |                                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                          |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>                                                                                                                                                                                                                                                                                                                                                                                           |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |                                                                                     | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Carpenter</b>                                                                        |                                                                                          |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                        | 13b. CITY OR TOWN<br><b>Montgomery</b>                                              |                                                                                                                                                          | 13c. CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST <b>Ross</b> MIDDLE <b>E.</b> LAST <b>Holland</b>                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Lenora</b> MIDDLE <b>J.</b> LAST <b>King</b>   |                                                                                                                                                          |                                                                                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                     |                         | 16b. SOCIAL SECURITY NO.<br><b>218-90-5754</b>                                                                                         |                                                                                     | 17. INFORMANT<br><b>Ross E. Holland</b> ADDRESS<br><b>Father Same as 13</b>                                                                              |                                                                                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>multiple injuries Severe</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |                         |                                                                                                                                        |                                                                                     |                                                                                                                                                          |                                                                                          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                        |                                                                                     |                                                                                                                                                          |                                                                                          |
| 19a. DATE OF OPERATION<br><b>10.6.83</b>                                                                                                                                                                                                                                                                                                                                                                                               |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>Ruptured ventricle</b>                                                         |                                                                                     | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                      |                                                                                          |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                         |                         | 21b. TIME OF INJURY<br>HOUR _____ MONTH _____ DAY _____ YEAR _____<br><b>10 31 P.M. 10 5 1983</b>                                      |                                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>motorcycle accident</b>                                              |                                                                                          |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                      |                         | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)<br><b>Street</b>                                                            |                                                                                     | 21f. LOCATION<br>STREET <b>Gaithersburg</b> CITY OR TOWN <b>montgomery</b> COUNTY <b>md</b> STATE                                                        |                                                                                          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |                                                                                                                                        |                                                                                     |                                                                                                                                                          |                                                                                          |
| ACTUAL SIGNATURE<br><b>John Tauber</b>                                                                                                                                                                                                                                                                                                                                                                                                 |                         | TITLE (SPECIFY)<br><b>Bethesda md.</b>                                                                                                 |                                                                                     | DATE SIGNED<br><b>10-6-83</b>                                                                                                                            |                                                                                          |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>John Tauber</b>                                                                                                                                                                                                                                                                                                                                                                               |                         | ADDRESS<br><b>8218 Wisconsin ave</b>                                                                                                   |                                                                                     |                                                                                                                                                          |                                                                                          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                             |                         | 23b. DATE<br><b>Oct. 8, 1983</b>                                                                                                       |                                                                                     | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Carmel Cemetery</b>                                                                                         |                                                                                          |
| 24. FUNERAL DIRECTOR NAME<br><b>Francis J. Collins</b>                                                                                                                                                                                                                                                                                                                                                                                 |                         | 23d. LOCATION<br>CITY OR TOWN <b>Littlestown</b> COUNTY <b>Adams</b> STATE <b>Penn.</b>                                                |                                                                                     | 25. DATE REC'D. BY REGISTRAR<br><b>OCT 13 1983</b>                                                                                                       |                                                                                          |
| 500 University Blvd., W. Silver Spring, Md.                                                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                        |                                                                                     |                                                                                                                                                          |                                                                                          |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                        |                                                                |                                                                                                                                                            |                                                                                                                         |                                                                                   |                                                                                |                                                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|--|
| 1 - STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        |                                                                |                                                                                                                                                            | REG. NO.                                                                                                                |                                                                                   |                                                                                |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Vivian S. HOUSTON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |                                                                |                                                                                                                                                            | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Oct. 31, 1983</b>                                                                |                                                                                   |                                                                                | 2b. HOUR<br><b>11:08AM</b>                                                                                              |  |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4 RACE<br><b>White</b>                                                                                                                 |                                                                | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Dec. 30, 1902</b>                                                                                                    |                                                                                                                         | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS                                   |                                                                                | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                          |                                                                | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                         | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery Co., MD.</b>                 |                                                                                |                                                                                                                         |  |
| 10 CITY OR TOWN OF DEATH<br><b>Rockville</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Shady Grove Adventist</b> |                                                                |                                                                                                                                                            |                                                                                                                         | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b> |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov't.</b>                                                                 |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                        |                                                                |                                                                                                                                                            | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |                                                                                   |                                                                                |                                                                                                                         |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY<br><b>Montgomery</b>                                                                                                       |                                                                | 13c. CITY OR TOWN<br><b>Damascus</b>                                                                                                                       |                                                                                                                         | 13e. STREET ADDRESS<br><b>12011 Bethesda Church Rd. 20872</b>                     |                                                                                |                                                                                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Charles H. Scott</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                        |                                                                |                                                                                                                                                            | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Elizabeth Rucker</b>                                                   |                                                                                   |                                                                                |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                        |                                                                |                                                                                                                                                            | 16b. SOCIAL SECURITY NO.<br><b>228-05-4403</b>                                                                          |                                                                                   | 17 INFORMANT ADDRESS<br><b>Charles W. Houston, Item 13</b>                     |                                                                                                                         |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Cardio-vascular arrest</b><br><b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic obstructive Pul. Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerotic vascular Disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b><br><b>15 yrs</b><br><b>15 yrs</b> |  |                                                                                                                                        |                                                                |                                                                                                                                                            |                                                                                                                         |                                                                                   |                                                                                |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Transitional dehydration, Hypertension</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                        |                                                                |                                                                                                                                                            |                                                                                                                         |                                                                                   |                                                                                |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED               |                                                                                                                                                            |                                                                                                                         | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b> |                                                                                                                                                            |                                                                                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |                                                                                |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                        | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC) |                                                                                                                                                            |                                                                                                                         | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |                                                                                |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/31/83</b> to <b>10/31/83</b> , that (I) (we) last saw the deceased alive on <b>10/31/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                                      |  |                                                                                                                                        |                                                                |                                                                                                                                                            |                                                                                                                         |                                                                                   |                                                                                |                                                                                                                         |  |
| 22b. SIGNATURE<br><b>Stephen N. Jones, N.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        |                                                                |                                                                                                                                                            | DEGREE<br><b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                   |                                                                                | 22c. DATE SIGNED<br><b>10/31/83</b>                                                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                        |                                                                |                                                                                                                                                            | 22e. ADDRESS<br><b>809 Veirs Mill Rd., Rockville, Md.</b>                                                               |                                                                                   |                                                                                |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                        | 23b. DATE<br><b>Nov. 2, 1983</b>                               |                                                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Appomattox</b>                                                                 |                                                                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Hopewell, Prince George, Va.</b> |                                                                                                                         |  |
| 24. FUNERAL DIRECTOR<br><b>Orin L. Molesworth, P.A.,</b> ADDRESS<br><b>Damascus, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                        |                                                                |                                                                                                                                                            | 25. DATE RECEIVED BY REGISTRAR<br><b>NOV 02 1983</b>                                                                    |                                                                                   |                                                                                |                                                                                                                         |  |

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May 21, 1943

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                             |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |  | 83 27719                                |                  |                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------|------------------|-------------------|-------------------------------------------------|
| 1- FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                     |  | REG. NO.                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |  |                                         |                  |                   |                                                 |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                              |  | FIRST<br><b>Elias</b>                                                                                                                           |  | MIDDLE<br><b>WOODROW</b>                                                                                                                                    |  | LAST<br><b>Howes</b>                                                                            |  | 2a. DATE OF DEATH                                                                                                             |  | MONTH<br><b>10</b>                      | DAY<br><b>19</b> | YEAR<br><b>83</b> | 2b. HOUR<br><b>3:25AM</b>                       |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>WHITE</b>                                                                                                                         |  | 5. DATE OF BIRTH<br>MONTH<br><b>Dec. 31</b> , YEAR<br><b>1916</b>                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b>                                                    |  | IF UNDER 1 YEAR<br>MONTHS<br><b>YRS.</b>                                                                                      |  | IF UNDER 24 HRS<br>HOURS<br><b>MIN.</b> |                  |                   |                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                      |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |  |                                                                                                                               |  |                                         |                  |                   |                                                 |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |  |                                         |                  |                   |                                                 |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>carpenter</b>                                                                                                                                                                                                                                                                             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>construction</b>                                                                                        |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |  |                                         |                  |                   |                                                 |
| 13a. STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY<br><b>Mont.</b>                                                                                                                     |  | 13c. CITY OR TOWN<br><b>Olney</b>                                                                                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>Olney Laytonsville Rd. 20832</b>                                                                    |  |                                         |                  |                   |                                                 |
| 14. FATHER'S NAME<br>FIRST<br><b>Elias</b> MIDDLE<br><b>R.</b> LAST<br><b>Howes</b>                                                                                                                                                                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>Susie</b> MIDDLE<br><b>R.</b> LAST<br><b>Howes</b>                                                      |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |  |                                         |                  |                   |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br><b>1940-1945</b>                                                                                                    |  | 17. INFORMANT<br><b>Kenneth W. Howes</b> ADDRESS<br><b>1301 Coral Sea Dr. Rockville, Md. 20851</b>                                                          |  |                                                                                                 |  |                                                                                                                               |  |                                         |                  |                   |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>METASTATIC POORLY DIFFERENTIATED SQUAMOUS CELL CANCER</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>IDIOPATHIC INTERSTITIAL FIBROSIS</b>                    |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |  |                                         |                  |                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                              |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |  |                                         |                  |                   |                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                         |                  |                   |                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                               |  |                                         |                  |                   |                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                          |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                               |  |                                         |                  |                   |                                                 |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>7</b> , 19 <b>82</b> , to <b>10/19</b> , 19 <b>83</b> , that (1) (we) last saw the deceased alive on <b>10/18</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |  |                                         |                  |                   |                                                 |
| 22b. SIGNATURE<br><b>Evelyn Jackson</b>                                                                                                                                                                                                                                                                                                                          |  | DEGREE                                                                                                                                          |  | 22c. DATE SIGNED<br><b>10/19/83</b>                                                                                                                         |  |                                                                                                 |  |                                                                                                                               |  |                                         |                  |                   |                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Evelyn Jackson, MD</b>                                                                                                                                                                                                                                                                                               |  | 22e. ADDRESS<br><b>540 TEN OAKS RD URBANVILLE MD</b>                                                                                            |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |  |                                         |                  |                   |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br><b>OCT. 21, 1983</b>                                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Carmel</b>                                                                                                     |  |                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sunshine Mont. Md.</b>                                                       |  |                                         |                  |                   |                                                 |
| 24. FUNERAL DIRECTOR<br><b>FRANCIS H. BARBER</b>                                                                                                                                                                                                                                                                                                                 |  | LAYTONSVILLE, MD. 20879                                                                                                                         |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 21 1983</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canfield</b>                                           |  |                                                                                                                               |  |                                         |                  |                   |                                                 |

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CHILFAR 111



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 27720

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                              |  |                                                                                                                                         |                                                 |                                                                                                                                                                                                                                                                                                                                                                             |                           |                                                                                                                         |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>AGNES B. HUMPHREY</b>                                                                                                                                                 |  |                                                                                                                                         | 2a. DATE OF DEATH MONTH DAY YEAR <b>10/8/83</b> |                                                                                                                                                                                                                                                                                                                                                                             | 2b. HOUR <b>5:05 P.M.</b> |                                                                                                                         |  |
| 3. SEX <b>FEMALE</b>                                                                                                                                                                                         |  | 4. RACE <b>WHITE</b>                                                                                                                    |                                                 | 5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 3, 1893</b>                                                                                                                                                                                                                                                                                                                        |                           | 6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.                                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                              |                                                 | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                    |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD.</b>                                                       |  |
| 10. CITY OR TOWN OF DEATH <b>KENSINGTON</b>                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CIRCLE MANOR NURSING HOME</b> |                                                 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SWITCHBOARD OPERATOR</b>                                                                                                                                                                                                                                                                                   |                           | 12b. KIND OF BUSINESS OR INDUSTRY <b>SWITCH BOARD</b>                                                                   |  |
| 13a. STATE <b>MARYLAND</b>                                                                                                                                                                                   |  | 13b. COUNTY <b>MONTGOMERY</b>                                                                                                           |                                                 | 13c. CITY OR TOWN <b>KENSINGTON</b>                                                                                                                                                                                                                                                                                                                                         |                           | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM - BREEN</b>                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY - LALLY</b>                                                                          |                                                 | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                                                 |                           | 16b. SOCIAL SECURITY NO. <b>579-22-2998</b>                                                                             |  |
| 17. INFORMANT <b>RAYMOND HUMPHREY</b>                                                                                                                                                                        |  | ADDRESS <b>191 PLYMOUTH LA. MD.</b>                                                                                                     |                                                 | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RIGHT LOWER LOBE PNEUMONIA</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ONE WEEK</b>                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>chronic organic brain syndrome with senile dementia and incontinence</b> |  |                                                                                                                                         |                                                 |                                                                                                                                                                                                                                                                                                                                                                             |                           |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                        |                                                 | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                           |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                           |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                    |                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                                                                                                                                                                                                                                                                                              |                           |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                       |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                     |                                                 | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                                              |                           |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 5, 1983</b> to <b>OCT 8, 1983</b> , that (I) (we) lost <b>above (I) (we) (did) (did not) view the body after death.</b>            |  |                                                                                                                                         |                                                 |                                                                                                                                                                                                                                                                                                                                                                             |                           |                                                                                                                         |  |
| 22b. SIGNATURE <b>Martin C. Shargel</b>                                                                                                                                                                      |  | DEGREE <b>M.D.</b>                                                                                                                      |                                                 | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                                                                                                                                                                                                                  |                           | 22c. DATE SIGNED <b>10/8/83</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARTIN C. SHARGEL</b>                                                                                                                                               |  | 22e. ADDRESS <b>3720 FARRAGUT AVE KENSINGTON MD-20895</b>                                                                               |                                                 |                                                                                                                                                                                                                                                                                                                                                                             |                           |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>                                                                                                                                                      |  | 23b. DATE <b>OCT. 12, 1983</b>                                                                                                          |                                                 | 23c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>                                                                                                                                                                                                                                                                                                                 |                           | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROCKVILLE, MONTGOMERY MARYLAND</b>                                           |  |
| 24. FUNERAL DIRECTOR NAME <b>CHAMBERS FUNERAL HOME</b>                                                                                                                                                       |  | ADDRESS <b>SILVER SPRING, MARYLAND</b>                                                                                                  |                                                 | 25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1983</b>                                                                                                                                                                                                                                                                                                                            |                           | REGISTRAR'S SIGNATURE                                                                                                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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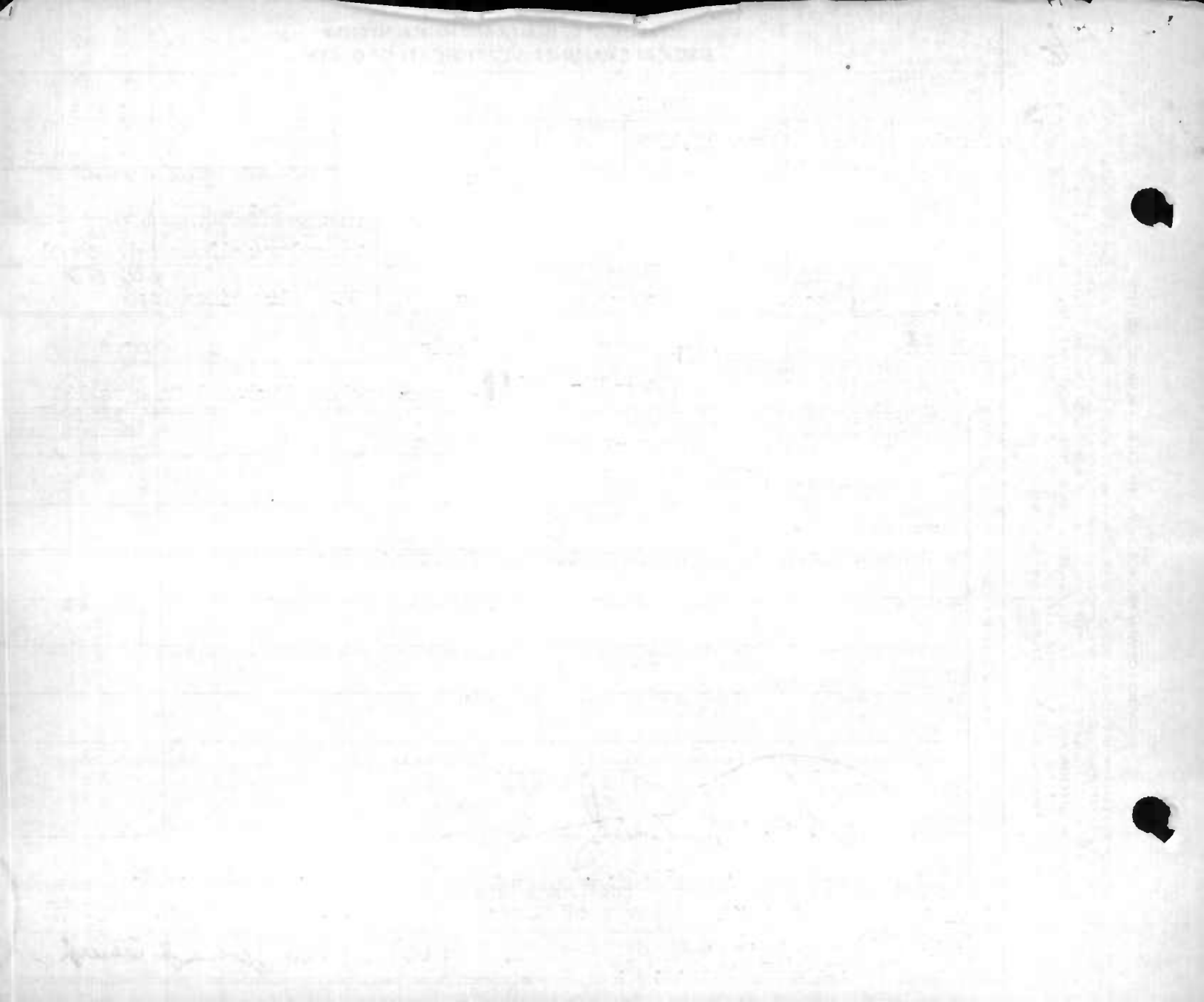
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10/8/83

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                 |                              |                                                                                                                                                             |                                                          |                                                                                               |  |                                                                                     |  | REG. NO.<br>27721 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------------------------------------------------|------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|-------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST: Maude, MIDDLE: Huil, LAST: Hughes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                 |                              |                                                                                                                                                             |                                                          | 2a. DATE KNOWN OF DEATH<br>MONTH: 10, DAY: 2, YEAR: 1983                                      |  | 2b. HOUR<br>M                                                                       |  |                   |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4. RACE<br>Black | 5. DATE OF BIRTH<br>Nov. 12, 1928                                                                                               | 6. AGE (IN YEARS)<br>54 YRS. | 7. IF UNDER 1 YR.<br>MONTHS: , DAYS: , HOURS: , MIN: .                                                                                                      | 8. IF UNDER 24 HRS.<br>MONTHS: , DAYS: , HOURS: , MIN: . | 2c. DATE PRONOUNCED DEAD<br>MONTH: 10, DAY: 2, YEAR: 1983                                     |  | 2d. HOUR<br>5P M                                                                    |  |                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Guyana                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                             |                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD.                                |  |                                                                                     |  |                   |
| 10. CITY OR TOWN OF DEATH<br>Bethesda                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |                              |                                                                                                                                                             |                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Counselor Ballou High School |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                   |  |                   |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                 |                              |                                                                                                                                                             |                                                          | 13b. COUNTY<br>Mont.                                                                          |  | 13c. CITY OR TOWN<br>Bethesda                                                       |  |                   |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                 |                              |                                                                                                                                                             |                                                          | 13e. STREET ADDRESS<br>5609 Alta Vista Road                                                   |  |                                                                                     |  |                   |
| 14. FATHER'S NAME<br>FIRST: Albert, MIDDLE: , LAST: Stephenson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                 |                              | 15. MOTHER'S MAIDEN NAME<br>FIRST: Viola, MIDDLE: , LAST: Moses                                                                                             |                                                          |                                                                                               |  |                                                                                     |  |                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  | 16b. SOCIAL SECURITY NO.<br>069-30-4891                                                                                         |                              | 17. INFORMANT<br>Patrick Hughes (Husband) Same as 13E                                                                                                       |                                                          |                                                                                               |  |                                                                                     |  |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u><br>4360<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ |                  |                                                                                                                                 |                              |                                                                                                                                                             |                                                          |                                                                                               |  |                                                                                     |  |                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                 |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                           |                                                          |                                                                                               |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                      |                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                                          |                                                                                               |  |                                                                                     |  |                   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                     |                              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                          |                                                                                               |  |                                                                                     |  |                   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .                                                                                                                                                             |                  |                                                                                                                                 |                              |                                                                                                                                                             |                                                          |                                                                                               |  |                                                                                     |  |                   |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                                                                                                 |                              | TITLE (SPECIFY)<br>M.D. Deputy Chief                                                                                                                        |                                                          |                                                                                               |  | DATE SIGNED<br>10/4/83                                                              |  |                   |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                  |                                                                                                                                 |                              | ADDRESS<br>111 Penn St. Balto., MD.                                                                                                                         |                                                          |                                                                                               |  |                                                                                     |  |                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 23b. DATE<br>10/8/83                                                                                                            |                              | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven                                                                                                        |                                                          | 23d. LOCATION<br>CITY OR TOWN: S.S. COUNTY: Mont. STATE: Maryland                             |  |                                                                                     |  |                   |
| 24. NAME OF FUNERAL HOME<br>Hines/Rinaldi Funeral Home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                 |                              | 25a. DATE REC'D BY REGISTRAR<br>OCT 11 1983                                                                                                                 |                                                          | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Coughlin</i>                                         |  |                                                                                     |  |                   |
| 11800 New Hampshire Ave. S.S. Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                 |                              |                                                                                                                                                             |                                                          |                                                                                               |  |                                                                                     |  |                   |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                    |  |                                                                                                                                         |                                                                      |                                                                                                                                                             |                                     |                                                                                             |                                                                                                 |                                                          |                                                 |  |
|--------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNA (Moore) HUTCHINSON</b> |  |                                                                                                                                         | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10-21-83</b>                  |                                                                                                                                                             |                                     | 2b. HOUR<br><b>7:20<sup>P</sup></b>                                                         |                                                                                                 |                                                          |                                                 |  |
| 3. SEX<br><b>Female</b>                                            |  | 4. RACE<br><b>Caucasian</b>                                                                                                             |                                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6-21-20</b>                                                                                                        |                                     | 6. AGE, (IN YEARS LAST BIRTHDAY)<br><b>63</b>                                               |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                |                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                           |                                                                      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY MD.</b>                               |                                                                                                 |                                                          |                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |                                                                      |                                                                                                                                                             |                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Fiscal Assistant</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Space Center</b> |                                                 |  |
| 13a. STATE<br><b>Maryland</b>                                      |  |                                                                                                                                         | 13b. COUNTY<br><b>Pr. Geo.</b>                                       |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Adelphi</b> |                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                          | 13e. STREET ADDRESS<br><b>1729 Keokee Court</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry M. Moore</b>    |  |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anita Barber</b> |                                                                                                                                                             |                                     | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>              |                                                                                                 |                                                          |                                                 |  |
| 16b. SOCIAL SECURITY NO.<br><b>236-20-6326</b>                     |  |                                                                                                                                         | 17. INFORMANT<br><b>Husband</b>                                      |                                                                                                                                                             |                                     | ADDRESS<br><b>Same as 13</b>                                                                |                                                                                                 |                                                          |                                                 |  |

|                                                                                                                                                                                                                                                                                          |  |                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Adenocarcinoma of Breast</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>6 YRS</b> |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

|                                                                                                                                                                                                                                                                                                                                                         |  |                                                                        |  |                                                                                |  |                                                                                                                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 27, 1977</b> to <b>OCTOBER 26, 1983</b> , that we (we) last saw the deceased alive on <b>OCTOBER 21, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>James H. Brown</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                        |  | DEGREE<br><b>ATTENDING PHYSICIAN</b>                                           |  | 22c. DATE SIGNED<br><b>10/21/83</b>                                                                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES H. BROWN, MD</b>                                                                                                                                                                                                                                                                                      |  |                                                                        |  | 22e. ADDRESS<br><b>6125 BELCAST RD<br/>HATTSVILLE MD 20782</b>                 |  |                                                                                                                               |  |

|                                                               |  |                                   |  |                                                                   |  |                                                                                  |  |
|---------------------------------------------------------------|--|-----------------------------------|--|-------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>Oct. 27, 1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood Pr. Geo. Maryland</b> |  |
|---------------------------------------------------------------|--|-----------------------------------|--|-------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|

|                                                           |  |                                                     |  |                                                     |  |
|-----------------------------------------------------------|--|-----------------------------------------------------|--|-----------------------------------------------------|--|
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Francis J. Collins</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 27 1983</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b> |  |
| 500 University Blvd., W. Silver Spring, Md.               |  |                                                     |  |                                                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                   |  |                                                                                                                                         |                                                     |                                                                                                                                                             |  |                                                                                                      |  |                                                       |  |
|-----------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Charles R Hutcherson</b>                   |  |                                                                                                                                         | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10-31-83</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>6:45 A.M.</b>                                                                         |  |                                                       |  |
| 3. SEX<br><b>Male</b>                                                             |  | 4. RACE<br><b>Caucasian</b>                                                                                                             |                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 27, 1917</b>                                                                                                 |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.                                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                              |                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                        |  |                                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |                                                     |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Carpenter</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Building</b>  |  |
| 13a. STATE<br><b>Maryland</b>                                                     |  | 13b. COUNTY<br><b>Montgomery</b>                                                                                                        |                                                     | 13c. CITY OR TOWN<br><b>Silver Spg</b>                                                                                                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  | 13e. STREET ADDRESS<br><b>14221 Georgia Ave 20906</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Raleigh nmh Hutcherson</b>           |  |                                                                                                                                         |                                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Virginia nmh Cane</b>                                                                                   |  |                                                                                                      |  |                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  |                                                                                                                                         |                                                     | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>None</b>                                                                                      |  | 17. INFORMANT<br>ADDRESS<br><b>14221 Georgia Ave</b><br><b>Constance Hutcherson, Silver Spg., Md</b> |  |                                                       |  |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**4100**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

**Myocardial Infarction**  
**Respiratory Arrest**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)

**BRAIN DEATH**

|                                                                                                                                                                                                                                                                                                              |  |                                                                        |  |                                                                                      |  |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)       |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/19</b> 19 <b>83</b> to <b>10/31</b> 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>10/31</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. |  |                                                                        |  |                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Hector K. Collison</b>                                                                                                                                                                                                                                                                  |  |                                                                        |  | DEGREE<br><b>MD</b>                                                                  |  | 22c. DATE SIGNED<br><b>10/31/83</b>                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HECTOR K. COLLISON MD</b>                                                                                                                                                                                                                                        |  |                                                                        |  | 22e. ADDRESS<br><b>117 SONINA ST SILVER SPRING MD</b>                                |  |                                                                                                                            |  |

|                                                                                              |  |                                  |  |                                                                                           |  |                                            |  |
|----------------------------------------------------------------------------------------------|--|----------------------------------|--|-------------------------------------------------------------------------------------------|--|--------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                   |  | 23b. DATE<br><b>Nov. 4, 1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dry Fork, P.H. Cemty Dry Fork, N/A, Virginia</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>W.W. Chambers Co, 8655 Georgia Ave, Sil. Spg.</b> |  |                                  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 7 1983</b>                                        |  |                                            |  |
|                                                                                              |  |                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                          |  |                                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Handwritten text, possibly a signature or name, appearing as "Kemp" or similar.

20% COTTON  
Handwritten text, possibly a date or reference number, appearing as "1944" or similar.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                   |  |                                                                                                                                                      |                                                               |                                                                                                                                                             |  |                                                                                                 |  |                                                                  |  |
|-----------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Stella Mae Hutchison</b>                |  |                                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 4, 1983</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>7:15 pm</b>                                                                      |  |                                                                  |  |
| 3. SEX<br><b>Female</b>                                                           |  | 4. RACE<br><b>White</b>                                                                                                                              |                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>January 27, 1930</b>                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS.                                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                           |                                                               | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                            |  |                                                                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Clinical Center, NIH, Beth., Md.</b> |                                                               |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>home</b>                 |  |
| 13a. STATE<br><b>Virginia</b>                                                     |  | 13b. COUNTY<br><b>none</b>                                                                                                                           |                                                               | 13c. CITY OR TOWN<br><b>Roanoke</b>                                                                                                                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>406 Tazewell Ave., Se 24013</b>        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Archie B. Thurman</b>                |  |                                                                                                                                                      |                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edna L. Edwards</b>                                                                                     |  |                                                                                                 |  |                                                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>229-32-1230</b>                                                                        |                                                               | 17. INFORMANT<br>ADDRESS<br><b>Mr. Hubert Thurman (son) Same as Patient</b>                                                                                 |  |                                                                                                 |  |                                                                  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Intraoperative death: Cardiac pathology**  
 pending:  
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  
 (b) **Severe atherosclerosis with severe left renal atrophy.**  
 DUE TO, OR AS A CONSEQUENCE OF  
 (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                  |  |                                                                                               |  |                                                                                                                                       |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION<br><b>10/4/83</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Abnormal vitral valve</b> |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                 |  |                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)           |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                             |  |                                                                                                                                       |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 9, 1983</b> to <b>October 4, 1983</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>October 4, 1983</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. |  |                                                                                  |  |                                                                                               |  |                                                                                                                                       |  |
| 22b. SIGNATURE<br><b>Jose Montalva Jr MD</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                  |  | DEGREE<br><b>MD</b>                                                                           |  | 22c. DATE SIGNED<br><b>10-5-83</b>                                                                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jose Montalva Jr MD</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                  |  | 22e. ADDRESS<br><b>National Institutes of Health<br/>Clinical Center, Bethesda, Md. 20205</b> |  |                                                                                                                                       |  |

|                                                               |  |                             |  |                                                                          |  |                                                             |  |
|---------------------------------------------------------------|--|-----------------------------|--|--------------------------------------------------------------------------|--|-------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>10/7/83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Blue Ridge Memorial Gardens</b> |  | 23d. LOCATION<br>(CITY OR TOWN)<br><b>Roanoke, Virginia</b> |  |
|---------------------------------------------------------------|--|-----------------------------|--|--------------------------------------------------------------------------|--|-------------------------------------------------------------|--|

|                                                                                                              |  |                                                     |  |                                                    |  |
|--------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|--|----------------------------------------------------|--|
| 24. FUNERAL DIRECTOR<br><b>Tyson Wheeler Funeral Home, Inc.<br/>1331 Rockville Pike Rockville, Md. 20852</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1983</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Smith</b> |  |
|--------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|--|----------------------------------------------------|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 7 2 5

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                |                                                                        |                                                                                                                                                             |                                                                     |                                                                                                                                            |                                                                                                 |                                                                                                                                       |                                                    |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Judith Huxley</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 17, 1983</b>         |                                                                                                                                                             | 2b. HOUR<br><b>4:25 PM</b>                                          |                                                                                                                                            |                                                                                                 |                                                                                                                                       |                                                    |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>White</b>                                                                                                        |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 3, 1926</b>                                                                                                   |                                                                     | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.                                                                                       |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                                      |                                                    |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MA</b>                                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                  |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                                                              |                                                                                                 |                                                                                                                                       |                                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Chevy Chase</b>                                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>100 Quincy St.</b> |                                                                        |                                                                                                                                                             |                                                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Writer-Editor</b>                                                   |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Newspaper</b>                                                                                 |                                                    |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md. 20815</b>                                                                                                                                                                                                                                                                                              |  |                                                                                                                                | 13b. COUNTY<br><b>Montgomery</b>                                       |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Chevy Chase</b>                             |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                       | 13e. STREET ADDRESS<br><b>160 Quincy St. 20815</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Max Wallet</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Doris Stroller</b> |                                                                                                                                                             |                                                                     |                                                                                                                                            |                                                                                                 |                                                                                                                                       |                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                | 16b. SOCIAL SECURITY NO.<br><b>031-12-4362</b>                         |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>Matthew Huxley Same as item # 13</b> |                                                                                                                                            |                                                                                                 |                                                                                                                                       |                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1749</b><br>(b) <b>Pulmonary emboli</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Metastatic breast carcinoma</b> |  |                                                                                                                                |                                                                        |                                                                                                                                                             |                                                                     |                                                                                                                                            |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>2 weeks</b><br><b>14 years</b>                                    |                                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I<br><b>Bullosis emphysemia Pleural effusion</b>                                                                                                                                                                                                                                         |  |                                                                                                                                |                                                                        |                                                                                                                                                             |                                                                     |                                                                                                                                            |                                                                                                 |                                                                                                                                       |                                                    |  |
| 19a. DATE OF OPERATION<br><b>10/5/83</b>                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Pleural effusion</b>                                                    |                                                                        |                                                                                                                                                             |                                                                     | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                       |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                              |                                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                     |                                                                                                                                            |                                                                                                 |                                                                                                                                       |                                                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                         |                                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                     |                                                                                                                                            |                                                                                                 |                                                                                                                                       |                                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 17 1983</b> to <b>Oct 17 1983</b> , that (I) (we) lost saw the deceased alive on <b>Oct 17 1983</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                 |  |                                                                                                                                |                                                                        |                                                                                                                                                             |                                                                     |                                                                                                                                            |                                                                                                 |                                                                                                                                       |                                                    |  |
| 22b. SIGNATURE<br><b>Rosalie Auster, MD</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                |                                                                        | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                     | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br><b>10/17/83</b>                                                                                                   |                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROSALIE AUSTER, M.D.</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                |                                                                        | 22e. ADDRESS<br><b>2038-18th St. N.W. D.C.</b>                                                                                                              |                                                                     |                                                                                                                                            |                                                                                                 |                                                                                                                                       |                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br><b>10/21/83</b>                                                                                                   |                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>                                                                                           |                                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland, Md.</b>                                                                         |                                                                                                 |                                                                                                                                       |                                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Joseph Gawler's Sons, Inc.</b><br><b>5130 Wisc. Ave. N.W. Wash., DC 20016</b>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                |                                                                        | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 25 1983</b>                                                                                                         |                                                                     | 25b. REGISTRAR'S SIGNATURE<br><b>J. O. Baird</b>                                                                                           |                                                                                                 |                                                                                                                                       |                                                    |  |

BP



Section

Building

Office of the

4-10-4

Thomas

Office

Dec. 3, 1942

100-10000

Cherry Grove

100-10000

100-10000

Box

100-10000

100-10000

No

100-10000

100-10000

RECEIVED  
FBI  
DEC 10 1942



100-10000  
100-10000  
100-10000

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 27126

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                              |                                                                                                        |                                                                                       |        |                                      |                                 |                                                                     |       |                         |      |            |
|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--------|--------------------------------------|---------------------------------|---------------------------------------------------------------------|-------|-------------------------|------|------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                          |                                                                                                        | FIRST                                                                                 | MIDDLE | LAST                                 | 20. DATE OF DEATH               |                                                                     | MONTH | DAY                     | YEAR | 20. HOUR   |
| Marl H. Hyde                                                                                 |                                                                                                        | Marl                                                                                  | H      | Hyde                                 | October 10, 1983                |                                                                     |       |                         |      | 8:16 PM    |
| 3. SEX                                                                                       | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                      |        | 6. AGE (IN YEARS LAST BIRTHDAY)      |                                 | IF UNDER 1 YEAR                                                     |       | IF UNDER 2 HRS          |      |            |
| Male                                                                                         | White                                                                                                  | July 16, 1903                                                                         |        | 80 YRS.                              |                                 | MONTHS                                                              |       | DAYS                    |      | HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                    | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |        | 9. BALTIMORE CITY OR COUNTY OF DEATH |                                 |                                                                     |       |                         |      |            |
| Maryland                                                                                     | USA                                                                                                    | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |        | Montgomery County, MD                |                                 |                                                                     |       |                         |      |            |
| 10. CITY OR TOWN OF DEATH                                                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                       |        |                                      | 12a. USUAL OCCUPATION           |                                                                     |       |                         |      |            |
| Silver Spring                                                                                | Holy Cross Hospital                                                                                    |                                                                                       |        |                                      | US Treasury Building Ass't Mgr. |                                                                     |       |                         |      |            |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |                                                                                                        | 13b. CITY OR TOWN                                                                     |        | 13d. INSIDE CITY LIMITS?             |                                 | 13e. STREET ADDRESS                                                 |       |                         |      |            |
| Maryland                                                                                     |                                                                                                        | Mont                                                                                  |        | S.S.                                 |                                 | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |       | 12908 Old Columbia Pike |      |            |
| 14. FATHER'S NAME                                                                            |                                                                                                        | 15. MOTHER'S MAIDEN NAME                                                              |        |                                      |                                 |                                                                     |       |                         |      |            |
| Walter C. Hyde                                                                               |                                                                                                        | Adeline Stuckey                                                                       |        |                                      |                                 |                                                                     |       |                         |      |            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)                     |                                                                                                        | 16b. SOCIAL SECURITY NO.                                                              |        | 17. INFORMANT                        |                                 | ADDRESS                                                             |       |                         |      |            |
| None                                                                                         |                                                                                                        | 214 07 6385                                                                           |        | Audrey M. Hyde (Wife)                |                                 | Same as 13E                                                         |       |                         |      |            |

## 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral Vasculature Accident

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

4360  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                                            |                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?                                                                                                                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|                                                                                                                                                                                                                                                                                                      |                                                                        | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                             |                                                                |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 83 to 10-10 19 83, that (I) (we) last saw the deceased alive on 10-10 19 83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |                                                                        |                                                                                                                                            |                                                                |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                       | DEGREE                                                                 | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED                                               |
| Gilbert B. Cushner                                                                                                                                                                                                                                                                                   | MD                                                                     |                                                                                                                                            | 10/14/83                                                       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                | 22e. ADDRESS                                                           |                                                                                                                                            |                                                                |
| Gilbert B. Cushner                                                                                                                                                                                                                                                                                   | 11161 New Hampshire Avenue S.S.Md.                                     |                                                                                                                                            |                                                                |

|                                             |           |                                       |                                      |
|---------------------------------------------|-----------|---------------------------------------|--------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (SP, BY)    | 23b. DATE | 23c. NAME OF FUNERAL HOME OR OPERATOR | 23d. LOCATION                        |
| Burial                                      | 10/13/83  | Frostburg Mem. Park                   | Frostburg, Allegany County, Maryland |
| 24. FUNERAL DIRECTOR                        |           | 25a. DATE REC'D. BY REGISTRAR         |                                      |
| Hines/Rinaldi Funeral Home                  |           | OCT 13 1983                           |                                      |
| 11800 New Hampshire Ave. Silver Spring, Md. |           | 25b. REGISTRAR'S SIGNATURE            |                                      |
|                                             |           | John J. Carver                        |                                      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP



CHIEF

20% COLON



BP \_\_\_\_\_

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE INDICATE THE REASON THEREON. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                           |                      |                                                                                                                                  |                                                |                                                                                                                                                          |                                             |                                                                                   |                                                                                  |                                                    |  | REG. NO.                                                                                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Barbara Lawlor Ibrahim</b>                                                                                                                                                                                                                                                                                                                                                                                    |                      |                                                                                                                                  |                                                |                                                                                                                                                          |                                             |                                                                                   |                                                                                  |                                                    |  | 2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH <b>10</b> DAY <b>18</b> YEAR <b>19 83</b> |
| 3. SEX <b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                              | 4. RACE <b>White</b> | 5. DATE OF BIRTH MONTH <b>7</b> DAY <b>13</b> YEAR <b>26</b>                                                                     | 6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS. | IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>                                                                                                               | IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b> | 7c. DATE PRONOUNCED DEAD <b>10-18-83</b>                                          | 7d. HOUR <b>8:35</b> M <b>A</b>                                                  |                                                    |  |                                                                                                                         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Canada</b>                                                                                                                                                                                                                                                                                                                                                                                           |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>Canada</b>                                                                                       |                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.                        |                                                                                  |                                                    |  |                                                                                                                         |
| 10. CITY OR TOWN OF DEATH <b>Bethesda</b>                                                                                                                                                                                                                                                                                                                                                                                                         |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b> |                                                |                                                                                                                                                          |                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Adm. Ass't.</b>  |                                                                                  | 12b. KIND OF BUSINESS OR INDUSTRY <b>WorldBank</b> |  |                                                                                                                         |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                        |                      |                                                                                                                                  |                                                |                                                                                                                                                          |                                             |                                                                                   |                                                                                  |                                                    |  |                                                                                                                         |
| 13a. STATE <b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |                      | 13b. COUNTY <b>MONTGOMERY</b>                                                                                                    |                                                | 13c. CITY OR TOWN <b>POTOMAC</b>                                                                                                                         |                                             | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                  | 13e. STREET ADDRESS <b>7863 HEATHERTON LANE</b>    |  |                                                                                                                         |
| 14. FATHER'S NAME FIRST <b>William J.</b> MIDDLE <b></b> LAST <b>Lawlor</b>                                                                                                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                  |                                                | 15. MOTHER'S MAIDEN NAME FIRST <b>Barbara</b> MIDDLE <b></b> LAST <b>Dingman</b>                                                                         |                                             |                                                                                   |                                                                                  |                                                    |  |                                                                                                                         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                                                                                                      |                      | (IF YES, GIVE WAR OR DATES)                                                                                                      |                                                | 16b. SOCIAL SECURITY NO. <b>320-34-1900</b>                                                                                                              |                                             | 17. INFORMANT <b>Walid Y. Ibrahim Same as item # 13</b>                           |                                                                                  |                                                    |  |                                                                                                                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>8129</b> IMMEDIATE CAUSE (a) <b>MULTIPLE TRAUMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>MOTOR VEHICLE ACCIDENT</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>                                                       |                      |                                                                                                                                  |                                                |                                                                                                                                                          |                                             |                                                                                   |                                                                                  |                                                    |  |                                                                                                                         |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                               |                      |                                                                                                                                  |                                                |                                                                                                                                                          |                                             |                                                                                   |                                                                                  |                                                    |  |                                                                                                                         |
| 19a. DATE OF OPERATION <b>-</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>-</b>                                                                       |                                                |                                                                                                                                                          |                                             |                                                                                   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                    |  |                                                                                                                         |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>8:35 PM 10 18 1983</b>                                                                                                                                                                                                                                                                                          |                      | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8:35 PM 10 18 1983</b>                                                           |                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>TURNED IN FRONT OF TRUCK</b>                                            |                                             |                                                                                   |                                                                                  |                                                    |  |                                                                                                                         |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                        |                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>STREET.</b>                                                       |                                                | 21f. LOCATION STREET <b>TUCKERMAN RD</b> CITY OR TOWN <b>POTOMAC</b> COUNTY <b>MONT.</b> STATE <b>MD</b>                                                 |                                             |                                                                                   |                                                                                  |                                                    |  |                                                                                                                         |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |                      |                                                                                                                                  |                                                |                                                                                                                                                          |                                             |                                                                                   |                                                                                  |                                                    |  |                                                                                                                         |
| ACTUAL SIGNATURE <b>Francis C. Mayhew</b>                                                                                                                                                                                                                                                                                                                                                                                                         |                      |                                                                                                                                  |                                                | TITLE (SPECIFY) <b>Sept</b> M.D.                                                                                                                         |                                             | MEDICAL EXAMINER                                                                  |                                                                                  | DATE SIGNED <b>10/18/83</b>                        |  |                                                                                                                         |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Francis C Mayhew</b>                                                                                                                                                                                                                                                                                                                                                                                           |                      |                                                                                                                                  |                                                | ADDRESS <b>8200 Wisconsin Ave Bethesda MD</b>                                                                                                            |                                             |                                                                                   |                                                                                  |                                                    |  |                                                                                                                         |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                                        |                      | 23b. DATE <b>10/20/83</b>                                                                                                        |                                                | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>                                                                                           |                                             | 23d. LOCATION CITY OR TOWN <b>Suitland, Md.</b> COUNTY <b></b> STATE <b></b>      |                                                                                  |                                                    |  |                                                                                                                         |
| 24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b> ADDRESS <b>5130 Wisc. Ave. N.W. Wash., DC 20016</b>                                                                                                                                                                                                                                                                                                                                   |                      |                                                                                                                                  |                                                | 25a. DATE REC'D. BY REGISTRAR <b>OCT 25 1983</b>                                                                                                         |                                             | 25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>                                  |                                                                                  |                                                    |  |                                                                                                                         |





4E80S



609 5 5 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                            |                                  |                                                                        |                                                                                                 | REG. NO.                                                                                                                                                    |                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                          |                                  |                                                                        |                                                                                                 | 8 3 2 7 1 2 8                                                                                                                                               |                                                               |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Vernon C. Jackson</b>                                                                                                                                                                                                                                                                                                    |                                  |                                                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>OCT-17-83</b>                                            |                                                                                                                                                             | 2b. HOUR<br>195 <b>AM</b>                                     |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br><b>White</b>          | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>March 24, 1927</b>               |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.                                                                                                           |                                                               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                    |                                  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                          |                                                                                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                               |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery Cty</b> MD.                                                                                                                                                                                                                                                                                               |                                  |                                                                        | 10. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Property Mgr.</b>         |                                                                                                                                                             |                                                               |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b>                                                                                                                                                                                                                           |                                  |                                                                        | 12. KIND OF BUSINESS OR INDUSTRY<br><b>Real Estate</b>                                          |                                                                                                                                                             |                                                               |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                     |                                  |                                                                        |                                                                                                 |                                                                                                                                                             |                                                               |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                        | 13b. COUNTY<br><b>Montgomery</b> | 13c. CITY OR TOWN<br><b>Bethesda</b>                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                                             |                                                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Leon G. Jackson</b>                                                                                                                                                                                                                                                                                                |                                  |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Laura Clagon</b>                            |                                                                                                                                                             |                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>                                                                                                                                                                                                                                                                                 |                                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>WW II</b>   |                                                                                                 | 17. INFORMANT<br>ADDRESS<br><b>Margaret G. Jackson, Same address as #13.</b>                                                                                |                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                       |                                  |                                                                        |                                                                                                 |                                                                                                                                                             |                                                               |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>                                                                                                                                                                                                                                                                                       |                                  |                                                                        |                                                                                                 |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 MIN</b> |
| 4100 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARDIOGENIC SHOCK</b>                                                                                                                                                                                                                                                                                           |                                  |                                                                        |                                                                                                 |                                                                                                                                                             | <b>72 HRS</b>                                                 |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>MYOCARDIAL INFARCTION</b>                                                                                                                                                                                             |                                  |                                                                        |                                                                                                 |                                                                                                                                                             | <b>1 WEEK</b>                                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>COPD, DIABETES MELLITUS</b>                                                                                                                                                                                          |                                  |                                                                        |                                                                                                 |                                                                                                                                                             |                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                          |                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                                               |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                      |                                  |                                                                        |                                                                                                 |                                                                                                                                                             |                                                               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                                               |
| 21d. INJURY OCCURRED<br>SHOULDER <input type="checkbox"/> RIGHT WRIST <input type="checkbox"/> LEFT WRIST <input type="checkbox"/>                                                                                                                                                                                                                              |                                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/16</b> 19 <b>83</b> , to <b>10/17</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>10/16</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                                  |                                                                        |                                                                                                 |                                                                                                                                                             |                                                               |
| 22b. SIGNATURE<br><b>Roger Stevenson, Jr.</b>                                                                                                                                                                                                                                                                                                                   |                                  | DEGREE                                                                 |                                                                                                 | 22c. DATE SIGNED<br><b>10/17/83</b>                                                                                                                         |                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROGER STEVENSON, JR MD</b>                                                                                                                                                                                                                                                                                          |                                  | 22e. ADDRESS<br><b>11125 ROCKVILLE PIKE ROCKVILLE, MD</b>              |                                                                                                 |                                                                                                                                                             |                                                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                   |                                  | 23b. DATE<br><b>10/17/83</b>                                           |                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>                                                                                            |                                                               |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, D.C.</b>                                                                                                                                                                                                                                                                                           |                                  |                                                                        |                                                                                                 |                                                                                                                                                             |                                                               |
| 24. FUNERAL DIRECTOR<br>NAME <b>Joseph Gawler's Sons, Inc.</b><br>ADDRESS <b>5130 Wisconsin Ave., NW, Washington, D.C. 20016</b>                                                                                                                                                                                                                                |                                  |                                                                        |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 24 1983</b>                                                                                                         |                                                               |
|                                                                                                                                                                                                                                                                                                                                                                 |                                  |                                                                        |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                                                                                                         |                                                               |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                               |  |                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                          |  |                                                                                   |  |                                                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                             |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                          |  | 2b. HOUR                                                                          |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                   |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                          |  | 2b. HOUR                                                                          |  |                                                                                                                         |  |
| 3. SEX                                                                                                                             |  | 4. RACE                                                                                                                                                                                                                                                                                                                         |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                   |  | 7. IF UNDER 1 YEAR                                                                                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                              |  | 10. MD.                                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                                                                                                                                                                                                          |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |
| 13a. STATE                                                                                                                         |  | 13b. COUNTY                                                                                                                                                                                                                                                                                                                     |  | 13c. CITY OR TOWN                                                                                                                                        |  | 14. STREET ADDRESS                                                                |  | 15. STREET ADDRESS                                                                                                      |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                      |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                        |  | 16b. SOCIAL SECURITY NO.                                                          |  | 17. INFORMANT ADDRESS                                                                                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:                              |  | 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u>                                                                                   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multiple Myeloma</u>                                                                         |  | 21e. INJURY OCCURRED (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                             |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  | 21g. DATE SIGNED                                                                  |  | 21h. DEGREE                                                                                                             |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                 |  | 22a. I certify that (I) (this hospital) attended the deceased from <u>10/12/83</u> to <u>10/28/83</u> , that (I) (we) last saw the deceased alive on <u>10/12/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE <u>M. Shepherd</u> MD                                                                                                                     |  | 22c. DATE SIGNED <u>10/28/83</u>                                                  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  | 23a. BURIAL, CREMATION, REMOVAL                                                                                                                                                                                                                                                                                                 |  | 23b. DATE                                                                                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY                                                |  | 23d. LOCATION                                                                                                           |  |
|                                                                                                                                    |  | 24. NAME OF FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                    |  | 25a. DATE REC'D BY REGISTRAR                                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE                                                        |  | 25c. REGISTRAR'S SIGNATURE                                                                                              |  |
|                                                                                                                                    |  | 26. NAME OF FUNERAL HOME                                                                                                                                                                                                                                                                                                        |  | 27. ADDRESS                                                                                                                                              |  | 28. CITY OR TOWN                                                                  |  | 29. COUNTY                                                                                                              |  |
|                                                                                                                                    |  | 30. STATE                                                                                                                                                                                                                                                                                                                       |  | 31. ZIP CODE                                                                                                                                             |  | 32. CITY OR TOWN                                                                  |  | 33. COUNTY                                                                                                              |  |
|                                                                                                                                    |  | 34. STATE                                                                                                                                                                                                                                                                                                                       |  | 35. ZIP CODE                                                                                                                                             |  | 36. CITY OR TOWN                                                                  |  | 37. COUNTY                                                                                                              |  |
|                                                                                                                                    |  | 38. STATE                                                                                                                                                                                                                                                                                                                       |  | 39. ZIP CODE                                                                                                                                             |  | 40. CITY OR TOWN                                                                  |  | 41. COUNTY                                                                                                              |  |
|                                                                                                                                    |  | 42. STATE                                                                                                                                                                                                                                                                                                                       |  | 43. ZIP CODE                                                                                                                                             |  | 44. CITY OR TOWN                                                                  |  | 45. COUNTY                                                                                                              |  |
|                                                                                                                                    |  | 46. STATE                                                                                                                                                                                                                                                                                                                       |  | 47. ZIP CODE                                                                                                                                             |  | 48. CITY OR TOWN                                                                  |  | 49. COUNTY                                                                                                              |  |
|                                                                                                                                    |  | 50. STATE                                                                                                                                                                                                                                                                                                                       |  | 51. ZIP CODE                                                                                                                                             |  | 52. CITY OR TOWN                                                                  |  | 53. COUNTY                                                                                                              |  |
|                                                                                                                                    |  | 54. STATE                                                                                                                                                                                                                                                                                                                       |  | 55. ZIP CODE                                                                                                                                             |  | 56. CITY OR TOWN                                                                  |  | 57. COUNTY                                                                                                              |  |
|                                                                                                                                    |  | 58. STATE                                                                                                                                                                                                                                                                                                                       |  | 59. ZIP CODE                                                                                                                                             |  | 60. CITY OR TOWN                                                                  |  | 61. COUNTY                                                                                                              |  |
|                                                                                                                                    |  | 62. STATE                                                                                                                                                                                                                                                                                                                       |  | 63. ZIP CODE                                                                                                                                             |  | 64. CITY OR TOWN                                                                  |  | 65. COUNTY                                                                                                              |  |
|                                                                                                                                    |  | 66. STATE                                                                                                                                                                                                                                                                                                                       |  | 67. ZIP CODE                                                                                                                                             |  | 68. CITY OR TOWN                                                                  |  | 69. COUNTY                                                                                                              |  |
|                                                                                                                                    |  | 70. STATE                                                                                                                                                                                                                                                                                                                       |  | 71. ZIP CODE                                                                                                                                             |  | 72. CITY OR TOWN                                                                  |  | 73. COUNTY                                                                                                              |  |
|                                                                                                                                    |  | 74. STATE                                                                                                                                                                                                                                                                                                                       |  | 75. ZIP CODE                                                                                                                                             |  | 76. CITY OR TOWN                                                                  |  | 77. COUNTY                                                                                                              |  |
|                                                                                                                                    |  | 78. STATE                                                                                                                                                                                                                                                                                                                       |  | 79. ZIP CODE                                                                                                                                             |  | 80. CITY OR TOWN                                                                  |  | 81. COUNTY                                                                                                              |  |
|                                                                                                                                    |  | 82. STATE                                                                                                                                                                                                                                                                                                                       |  | 83. ZIP CODE                                                                                                                                             |  | 84. CITY OR TOWN                                                                  |  | 85. COUNTY                                                                                                              |  |
|                                                                                                                                    |  | 86. STATE                                                                                                                                                                                                                                                                                                                       |  | 87. ZIP CODE                                                                                                                                             |  | 88. CITY OR TOWN                                                                  |  | 89. COUNTY                                                                                                              |  |
|                                                                                                                                    |  | 90. STATE                                                                                                                                                                                                                                                                                                                       |  | 91. ZIP CODE                                                                                                                                             |  | 92. CITY OR TOWN                                                                  |  | 93. COUNTY                                                                                                              |  |
|                                                                                                                                    |  | 94. STATE                                                                                                                                                                                                                                                                                                                       |  | 95. ZIP CODE                                                                                                                                             |  | 96. CITY OR TOWN                                                                  |  | 97. COUNTY                                                                                                              |  |
|                                                                                                                                    |  | 98. STATE                                                                                                                                                                                                                                                                                                                       |  | 99. ZIP CODE                                                                                                                                             |  | 100. CITY OR TOWN                                                                 |  | 101. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 102. STATE                                                                                                                                                                                                                                                                                                                      |  | 103. ZIP CODE                                                                                                                                            |  | 104. CITY OR TOWN                                                                 |  | 105. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 106. STATE                                                                                                                                                                                                                                                                                                                      |  | 107. ZIP CODE                                                                                                                                            |  | 108. CITY OR TOWN                                                                 |  | 109. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 110. STATE                                                                                                                                                                                                                                                                                                                      |  | 111. ZIP CODE                                                                                                                                            |  | 112. CITY OR TOWN                                                                 |  | 113. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 114. STATE                                                                                                                                                                                                                                                                                                                      |  | 115. ZIP CODE                                                                                                                                            |  | 116. CITY OR TOWN                                                                 |  | 117. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 118. STATE                                                                                                                                                                                                                                                                                                                      |  | 119. ZIP CODE                                                                                                                                            |  | 120. CITY OR TOWN                                                                 |  | 121. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 122. STATE                                                                                                                                                                                                                                                                                                                      |  | 123. ZIP CODE                                                                                                                                            |  | 124. CITY OR TOWN                                                                 |  | 125. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 126. STATE                                                                                                                                                                                                                                                                                                                      |  | 127. ZIP CODE                                                                                                                                            |  | 128. CITY OR TOWN                                                                 |  | 129. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 130. STATE                                                                                                                                                                                                                                                                                                                      |  | 131. ZIP CODE                                                                                                                                            |  | 132. CITY OR TOWN                                                                 |  | 133. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 134. STATE                                                                                                                                                                                                                                                                                                                      |  | 135. ZIP CODE                                                                                                                                            |  | 136. CITY OR TOWN                                                                 |  | 137. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 138. STATE                                                                                                                                                                                                                                                                                                                      |  | 139. ZIP CODE                                                                                                                                            |  | 140. CITY OR TOWN                                                                 |  | 141. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 142. STATE                                                                                                                                                                                                                                                                                                                      |  | 143. ZIP CODE                                                                                                                                            |  | 144. CITY OR TOWN                                                                 |  | 145. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 146. STATE                                                                                                                                                                                                                                                                                                                      |  | 147. ZIP CODE                                                                                                                                            |  | 148. CITY OR TOWN                                                                 |  | 149. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 150. STATE                                                                                                                                                                                                                                                                                                                      |  | 151. ZIP CODE                                                                                                                                            |  | 152. CITY OR TOWN                                                                 |  | 153. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 154. STATE                                                                                                                                                                                                                                                                                                                      |  | 155. ZIP CODE                                                                                                                                            |  | 156. CITY OR TOWN                                                                 |  | 157. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 158. STATE                                                                                                                                                                                                                                                                                                                      |  | 159. ZIP CODE                                                                                                                                            |  | 160. CITY OR TOWN                                                                 |  | 161. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 162. STATE                                                                                                                                                                                                                                                                                                                      |  | 163. ZIP CODE                                                                                                                                            |  | 164. CITY OR TOWN                                                                 |  | 165. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 166. STATE                                                                                                                                                                                                                                                                                                                      |  | 167. ZIP CODE                                                                                                                                            |  | 168. CITY OR TOWN                                                                 |  | 169. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 170. STATE                                                                                                                                                                                                                                                                                                                      |  | 171. ZIP CODE                                                                                                                                            |  | 172. CITY OR TOWN                                                                 |  | 173. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 174. STATE                                                                                                                                                                                                                                                                                                                      |  | 175. ZIP CODE                                                                                                                                            |  | 176. CITY OR TOWN                                                                 |  | 177. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 178. STATE                                                                                                                                                                                                                                                                                                                      |  | 179. ZIP CODE                                                                                                                                            |  | 180. CITY OR TOWN                                                                 |  | 181. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 182. STATE                                                                                                                                                                                                                                                                                                                      |  | 183. ZIP CODE                                                                                                                                            |  | 184. CITY OR TOWN                                                                 |  | 185. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 186. STATE                                                                                                                                                                                                                                                                                                                      |  | 187. ZIP CODE                                                                                                                                            |  | 188. CITY OR TOWN                                                                 |  | 189. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 190. STATE                                                                                                                                                                                                                                                                                                                      |  | 191. ZIP CODE                                                                                                                                            |  | 192. CITY OR TOWN                                                                 |  | 193. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 194. STATE                                                                                                                                                                                                                                                                                                                      |  | 195. ZIP CODE                                                                                                                                            |  | 196. CITY OR TOWN                                                                 |  | 197. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 198. STATE                                                                                                                                                                                                                                                                                                                      |  | 199. ZIP CODE                                                                                                                                            |  | 200. CITY OR TOWN                                                                 |  | 201. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 202. STATE                                                                                                                                                                                                                                                                                                                      |  | 203. ZIP CODE                                                                                                                                            |  | 204. CITY OR TOWN                                                                 |  | 205. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 206. STATE                                                                                                                                                                                                                                                                                                                      |  | 207. ZIP CODE                                                                                                                                            |  | 208. CITY OR TOWN                                                                 |  | 209. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 210. STATE                                                                                                                                                                                                                                                                                                                      |  | 211. ZIP CODE                                                                                                                                            |  | 212. CITY OR TOWN                                                                 |  | 213. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 214. STATE                                                                                                                                                                                                                                                                                                                      |  | 215. ZIP CODE                                                                                                                                            |  | 216. CITY OR TOWN                                                                 |  | 217. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 218. STATE                                                                                                                                                                                                                                                                                                                      |  | 219. ZIP CODE                                                                                                                                            |  | 220. CITY OR TOWN                                                                 |  | 221. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 222. STATE                                                                                                                                                                                                                                                                                                                      |  | 223. ZIP CODE                                                                                                                                            |  | 224. CITY OR TOWN                                                                 |  | 225. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 226. STATE                                                                                                                                                                                                                                                                                                                      |  | 227. ZIP CODE                                                                                                                                            |  | 228. CITY OR TOWN                                                                 |  | 229. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 230. STATE                                                                                                                                                                                                                                                                                                                      |  | 231. ZIP CODE                                                                                                                                            |  | 232. CITY OR TOWN                                                                 |  | 233. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 234. STATE                                                                                                                                                                                                                                                                                                                      |  | 235. ZIP CODE                                                                                                                                            |  | 236. CITY OR TOWN                                                                 |  | 237. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 238. STATE                                                                                                                                                                                                                                                                                                                      |  | 239. ZIP CODE                                                                                                                                            |  | 240. CITY OR TOWN                                                                 |  | 241. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 242. STATE                                                                                                                                                                                                                                                                                                                      |  | 243. ZIP CODE                                                                                                                                            |  | 244. CITY OR TOWN                                                                 |  | 245. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 246. STATE                                                                                                                                                                                                                                                                                                                      |  | 247. ZIP CODE                                                                                                                                            |  | 248. CITY OR TOWN                                                                 |  | 249. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 250. STATE                                                                                                                                                                                                                                                                                                                      |  | 251. ZIP CODE                                                                                                                                            |  | 252. CITY OR TOWN                                                                 |  | 253. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 254. STATE                                                                                                                                                                                                                                                                                                                      |  | 255. ZIP CODE                                                                                                                                            |  | 256. CITY OR TOWN                                                                 |  | 257. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 258. STATE                                                                                                                                                                                                                                                                                                                      |  | 259. ZIP CODE                                                                                                                                            |  | 260. CITY OR TOWN                                                                 |  | 261. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 262. STATE                                                                                                                                                                                                                                                                                                                      |  | 263. ZIP CODE                                                                                                                                            |  | 264. CITY OR TOWN                                                                 |  | 265. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 266. STATE                                                                                                                                                                                                                                                                                                                      |  | 267. ZIP CODE                                                                                                                                            |  | 268. CITY OR TOWN                                                                 |  | 269. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 270. STATE                                                                                                                                                                                                                                                                                                                      |  | 271. ZIP CODE                                                                                                                                            |  | 272. CITY OR TOWN                                                                 |  | 273. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 274. STATE                                                                                                                                                                                                                                                                                                                      |  | 275. ZIP CODE                                                                                                                                            |  | 276. CITY OR TOWN                                                                 |  | 277. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 278. STATE                                                                                                                                                                                                                                                                                                                      |  | 279. ZIP CODE                                                                                                                                            |  | 280. CITY OR TOWN                                                                 |  | 281. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 282. STATE                                                                                                                                                                                                                                                                                                                      |  | 283. ZIP CODE                                                                                                                                            |  | 284. CITY OR TOWN                                                                 |  | 285. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 286. STATE                                                                                                                                                                                                                                                                                                                      |  | 287. ZIP CODE                                                                                                                                            |  | 288. CITY OR TOWN                                                                 |  | 289. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 290. STATE                                                                                                                                                                                                                                                                                                                      |  | 291. ZIP CODE                                                                                                                                            |  | 292. CITY OR TOWN                                                                 |  | 293. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 294. STATE                                                                                                                                                                                                                                                                                                                      |  | 295. ZIP CODE                                                                                                                                            |  | 296. CITY OR TOWN                                                                 |  | 297. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 298. STATE                                                                                                                                                                                                                                                                                                                      |  | 299. ZIP CODE                                                                                                                                            |  | 300. CITY OR TOWN                                                                 |  | 301. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 302. STATE                                                                                                                                                                                                                                                                                                                      |  | 303. ZIP CODE                                                                                                                                            |  | 304. CITY OR TOWN                                                                 |  | 305. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 306. STATE                                                                                                                                                                                                                                                                                                                      |  | 307. ZIP CODE                                                                                                                                            |  | 308. CITY OR TOWN                                                                 |  | 309. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 310. STATE                                                                                                                                                                                                                                                                                                                      |  | 311. ZIP CODE                                                                                                                                            |  | 312. CITY OR TOWN                                                                 |  | 313. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 314. STATE                                                                                                                                                                                                                                                                                                                      |  | 315. ZIP CODE                                                                                                                                            |  | 316. CITY OR TOWN                                                                 |  | 317. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 318. STATE                                                                                                                                                                                                                                                                                                                      |  | 319. ZIP CODE                                                                                                                                            |  | 320. CITY OR TOWN                                                                 |  | 321. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 322. STATE                                                                                                                                                                                                                                                                                                                      |  | 323. ZIP CODE                                                                                                                                            |  | 324. CITY OR TOWN                                                                 |  | 325. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 326. STATE                                                                                                                                                                                                                                                                                                                      |  | 327. ZIP CODE                                                                                                                                            |  | 328. CITY OR TOWN                                                                 |  | 329. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 330. STATE                                                                                                                                                                                                                                                                                                                      |  | 331. ZIP CODE                                                                                                                                            |  | 332. CITY OR TOWN                                                                 |  | 333. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 334. STATE                                                                                                                                                                                                                                                                                                                      |  | 335. ZIP CODE                                                                                                                                            |  | 336. CITY OR TOWN                                                                 |  | 337. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 338. STATE                                                                                                                                                                                                                                                                                                                      |  | 339. ZIP CODE                                                                                                                                            |  | 340. CITY OR TOWN                                                                 |  | 341. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 342. STATE                                                                                                                                                                                                                                                                                                                      |  | 343. ZIP CODE                                                                                                                                            |  | 344. CITY OR TOWN                                                                 |  | 345. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 346. STATE                                                                                                                                                                                                                                                                                                                      |  | 347. ZIP CODE                                                                                                                                            |  | 348. CITY OR TOWN                                                                 |  | 349. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 350. STATE                                                                                                                                                                                                                                                                                                                      |  | 351. ZIP CODE                                                                                                                                            |  | 352. CITY OR TOWN                                                                 |  | 353. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 354. STATE                                                                                                                                                                                                                                                                                                                      |  | 355. ZIP CODE                                                                                                                                            |  | 356. CITY OR TOWN                                                                 |  | 357. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 358. STATE                                                                                                                                                                                                                                                                                                                      |  | 359. ZIP CODE                                                                                                                                            |  | 360. CITY OR TOWN                                                                 |  | 361. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 362. STATE                                                                                                                                                                                                                                                                                                                      |  | 363. ZIP CODE                                                                                                                                            |  | 364. CITY OR TOWN                                                                 |  | 365. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 366. STATE                                                                                                                                                                                                                                                                                                                      |  | 367. ZIP CODE                                                                                                                                            |  | 368. CITY OR TOWN                                                                 |  | 369. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 370. STATE                                                                                                                                                                                                                                                                                                                      |  | 371. ZIP CODE                                                                                                                                            |  | 372. CITY OR TOWN                                                                 |  | 373. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 374. STATE                                                                                                                                                                                                                                                                                                                      |  | 375. ZIP CODE                                                                                                                                            |  | 376. CITY OR TOWN                                                                 |  | 377. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 378. STATE                                                                                                                                                                                                                                                                                                                      |  | 379. ZIP CODE                                                                                                                                            |  | 380. CITY OR TOWN                                                                 |  | 381. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 382. STATE                                                                                                                                                                                                                                                                                                                      |  | 383. ZIP CODE                                                                                                                                            |  | 384. CITY OR TOWN                                                                 |  | 385. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 386. STATE                                                                                                                                                                                                                                                                                                                      |  | 387. ZIP CODE                                                                                                                                            |  | 388. CITY OR TOWN                                                                 |  | 389. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 390. STATE                                                                                                                                                                                                                                                                                                                      |  | 391. ZIP CODE                                                                                                                                            |  | 392. CITY OR TOWN                                                                 |  | 393. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 394. STATE                                                                                                                                                                                                                                                                                                                      |  | 395. ZIP CODE                                                                                                                                            |  | 396. CITY OR TOWN                                                                 |  | 397. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 398. STATE                                                                                                                                                                                                                                                                                                                      |  | 399. ZIP CODE                                                                                                                                            |  | 400. CITY OR TOWN                                                                 |  | 401. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 402. STATE                                                                                                                                                                                                                                                                                                                      |  | 403. ZIP CODE                                                                                                                                            |  | 404. CITY OR TOWN                                                                 |  | 405. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 406. STATE                                                                                                                                                                                                                                                                                                                      |  | 407. ZIP CODE                                                                                                                                            |  | 408. CITY OR TOWN                                                                 |  | 409. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 410. STATE                                                                                                                                                                                                                                                                                                                      |  | 411. ZIP CODE                                                                                                                                            |  | 412. CITY OR TOWN                                                                 |  | 413. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 414. STATE                                                                                                                                                                                                                                                                                                                      |  | 415. ZIP CODE                                                                                                                                            |  | 416. CITY OR TOWN                                                                 |  | 417. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 418. STATE                                                                                                                                                                                                                                                                                                                      |  | 419. ZIP CODE                                                                                                                                            |  | 420. CITY OR TOWN                                                                 |  | 421. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 422. STATE                                                                                                                                                                                                                                                                                                                      |  | 423. ZIP CODE                                                                                                                                            |  | 424. CITY OR TOWN                                                                 |  | 425. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 426. STATE                                                                                                                                                                                                                                                                                                                      |  | 427. ZIP CODE                                                                                                                                            |  | 428. CITY OR TOWN                                                                 |  | 429. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 430. STATE                                                                                                                                                                                                                                                                                                                      |  | 431. ZIP CODE                                                                                                                                            |  | 432. CITY OR TOWN                                                                 |  | 433. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 434. STATE                                                                                                                                                                                                                                                                                                                      |  | 435. ZIP CODE                                                                                                                                            |  | 436. CITY OR TOWN                                                                 |  | 437. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 438. STATE                                                                                                                                                                                                                                                                                                                      |  | 439. ZIP CODE                                                                                                                                            |  | 440. CITY OR TOWN                                                                 |  | 441. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 442. STATE                                                                                                                                                                                                                                                                                                                      |  | 443. ZIP CODE                                                                                                                                            |  | 444. CITY OR TOWN                                                                 |  | 445. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 446. STATE                                                                                                                                                                                                                                                                                                                      |  | 447. ZIP CODE                                                                                                                                            |  | 448. CITY OR TOWN                                                                 |  | 449. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 450. STATE                                                                                                                                                                                                                                                                                                                      |  | 451. ZIP CODE                                                                                                                                            |  | 452. CITY OR TOWN                                                                 |  | 453. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 454. STATE                                                                                                                                                                                                                                                                                                                      |  | 455. ZIP CODE                                                                                                                                            |  | 456. CITY OR TOWN                                                                 |  | 457. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 458. STATE                                                                                                                                                                                                                                                                                                                      |  | 459. ZIP CODE                                                                                                                                            |  | 460. CITY OR TOWN                                                                 |  | 461. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 462. STATE                                                                                                                                                                                                                                                                                                                      |  | 463. ZIP CODE                                                                                                                                            |  | 464. CITY OR TOWN                                                                 |  | 465. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 466. STATE                                                                                                                                                                                                                                                                                                                      |  | 467. ZIP CODE                                                                                                                                            |  | 468. CITY OR TOWN                                                                 |  | 469. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 470. STATE                                                                                                                                                                                                                                                                                                                      |  | 471. ZIP CODE                                                                                                                                            |  | 472. CITY OR TOWN                                                                 |  | 473. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 474. STATE                                                                                                                                                                                                                                                                                                                      |  | 475. ZIP CODE                                                                                                                                            |  | 476. CITY OR TOWN                                                                 |  | 477. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 478. STATE                                                                                                                                                                                                                                                                                                                      |  | 479. ZIP CODE                                                                                                                                            |  | 480. CITY OR TOWN                                                                 |  | 481. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 482. STATE                                                                                                                                                                                                                                                                                                                      |  | 483. ZIP CODE                                                                                                                                            |  | 484. CITY OR TOWN                                                                 |  | 485. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 486. STATE                                                                                                                                                                                                                                                                                                                      |  | 487. ZIP CODE                                                                                                                                            |  | 488. CITY OR TOWN                                                                 |  | 489. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 490. STATE                                                                                                                                                                                                                                                                                                                      |  | 491. ZIP CODE                                                                                                                                            |  | 492. CITY OR TOWN                                                                 |  | 493. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 494. STATE                                                                                                                                                                                                                                                                                                                      |  | 495. ZIP CODE                                                                                                                                            |  | 496. CITY OR TOWN                                                                 |  | 497. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 498. STATE                                                                                                                                                                                                                                                                                                                      |  | 499. ZIP CODE                                                                                                                                            |  | 500. CITY OR TOWN                                                                 |  | 501. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 502. STATE                                                                                                                                                                                                                                                                                                                      |  | 503. ZIP CODE                                                                                                                                            |  | 504. CITY OR TOWN                                                                 |  | 505. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 506. STATE                                                                                                                                                                                                                                                                                                                      |  | 507. ZIP CODE                                                                                                                                            |  | 508. CITY OR TOWN                                                                 |  | 509. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 510. STATE                                                                                                                                                                                                                                                                                                                      |  | 511. ZIP CODE                                                                                                                                            |  | 512. CITY OR TOWN                                                                 |  | 513. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 514. STATE                                                                                                                                                                                                                                                                                                                      |  | 515. ZIP CODE                                                                                                                                            |  | 516. CITY OR TOWN                                                                 |  | 517. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 518. STATE                                                                                                                                                                                                                                                                                                                      |  | 519. ZIP CODE                                                                                                                                            |  | 520. CITY OR TOWN                                                                 |  | 521. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 522. STATE                                                                                                                                                                                                                                                                                                                      |  | 523. ZIP CODE                                                                                                                                            |  | 524. CITY OR TOWN                                                                 |  | 525. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 526. STATE                                                                                                                                                                                                                                                                                                                      |  | 527. ZIP CODE                                                                                                                                            |  | 528. CITY OR TOWN                                                                 |  | 529. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 530. STATE                                                                                                                                                                                                                                                                                                                      |  | 531. ZIP CODE                                                                                                                                            |  | 532. CITY OR TOWN                                                                 |  | 533. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 534. STATE                                                                                                                                                                                                                                                                                                                      |  | 535. ZIP CODE                                                                                                                                            |  | 536. CITY OR TOWN                                                                 |  | 537. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 538. STATE                                                                                                                                                                                                                                                                                                                      |  | 539. ZIP CODE                                                                                                                                            |  | 540. CITY OR TOWN                                                                 |  | 541. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 542. STATE                                                                                                                                                                                                                                                                                                                      |  | 543. ZIP CODE                                                                                                                                            |  | 544. CITY OR TOWN                                                                 |  | 545. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 546. STATE                                                                                                                                                                                                                                                                                                                      |  | 547. ZIP CODE                                                                                                                                            |  | 548. CITY OR TOWN                                                                 |  | 549. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 550. STATE                                                                                                                                                                                                                                                                                                                      |  | 551. ZIP CODE                                                                                                                                            |  | 552. CITY OR TOWN                                                                 |  | 553. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 554. STATE                                                                                                                                                                                                                                                                                                                      |  | 555. ZIP CODE                                                                                                                                            |  | 556. CITY OR TOWN                                                                 |  | 557. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 558. STATE                                                                                                                                                                                                                                                                                                                      |  | 559. ZIP CODE                                                                                                                                            |  | 560. CITY OR TOWN                                                                 |  | 561. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 562. STATE                                                                                                                                                                                                                                                                                                                      |  | 563. ZIP CODE                                                                                                                                            |  | 564. CITY OR TOWN                                                                 |  | 565. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 566. STATE                                                                                                                                                                                                                                                                                                                      |  | 567. ZIP CODE                                                                                                                                            |  | 568. CITY OR TOWN                                                                 |  | 569. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 570. STATE                                                                                                                                                                                                                                                                                                                      |  | 571. ZIP CODE                                                                                                                                            |  | 572. CITY OR TOWN                                                                 |  | 573. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 574. STATE                                                                                                                                                                                                                                                                                                                      |  | 575. ZIP CODE                                                                                                                                            |  | 576. CITY OR TOWN                                                                 |  | 577. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 578. STATE                                                                                                                                                                                                                                                                                                                      |  | 579. ZIP CODE                                                                                                                                            |  | 580. CITY OR TOWN                                                                 |  | 581. COUNTY                                                                                                             |  |
|                                                                                                                                    |  | 582. STATE                                                                                                                                                                                                                                                                                                                      |  | 583. ZIP CODE                                                                                                                                            |  | 584. CITY OR TOWN                                                                 |  |                                                                                                                         |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 7 3 0

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                             |                                                                                                                                          |                                                                                                                                                             |                                                 |                                                                                                                                                                |                                                                  |
|-----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Evelyn C. JONES |                                                                                                                                          |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 16 83 |                                                                                                                                                                | 2b. HOUR<br>11:30 AM                                             |
| 3. SEX<br>Female                                                            | 4. RACE<br>Caucasian                                                                                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 25 20                                                                                                              |                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.                                                                                                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Pennsylvania                | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                                                                                                         |                                                                  |
| 10. CITY OR TOWN OF DEATH<br>Rockville                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SHADY GLENNS ADVENTIST HOSP |                                                                                                                                                             |                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Clerk Board of Education<br>12b. KIND OF BUSINESS OR INDUSTRY<br>Montgomery County |                                                                  |
| 13a. STATE<br>MD                                                            |                                                                                                                                          | 13b. COUNTY<br>Montgomery                                                                                                                                   | 13c. CITY OR TOWN<br>Germantown                 | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                           | 13e. STREET ADDRESS<br>19120 S. Johnsburg Ln 20874               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Krieger                    |                                                                                                                                          | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Barbara Bommer                                                                                             |                                                 |                                                                                                                                                                |                                                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |                                                                                                                                          | 16b. SOCIAL SECURITY NO.<br>165 18 1515                                                                                                                     |                                                 | 17. INFORMANT<br>ADDRESS<br>Elmer F. Jones same as 13e                                                                                                         |                                                                  |

|                                                                                                                                                                                                                                                                                                                                                                        |  |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br><u>5850</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Uremic Coma</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>Chronic Renal Failure</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

|                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        |                                                                                                                                            |                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                                                                            |
| 22a. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>9/1/83</u> , 19 <u>83</u> , to <u>10/16</u> , 19 <u>83</u> , that (I <del>was</del> ) lost<br>saw the deceased alive on <u>10/15</u> , 19 <u>83</u> , and that in (my <del>own</del> ) opinion death occurred on the date and hour and from the causes stated<br>above, (I <del>was</del> ) (I <del>did</del> ) view the body after death. |                                                                        |                                                                                                                                            |                                                                                                                            |
| 22b. SIGNATURE<br><u>Mark P. Rubin</u>                                                                                                                                                                                                                                                                                                                                                                                 | DEGREE<br>MD.                                                          | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>10/16/83                                                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARK P. RUBIN M.D.                                                                                                                                                                                                                                                                                                                                                            |                                                                        | 22e. ADDRESS<br>14805 Physicians Ln Rockville, MD                                                                                          |                                                                                                                            |

|                                                                                                                           |                       |                                                                               |                                                                    |
|---------------------------------------------------------------------------------------------------------------------------|-----------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                    | 23b. DATE<br>10/20/83 | 23c. NAME OF CEMETERY OR CREMATORY<br>Darnestown Presbyterian Church Cemetery | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Darnestown, Maryland |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Pyson Wheeler Funeral Home, Inc.<br>1331 Rockville Pike Rockville, Maryland 20852 |                       | 25. DATE REC'D. BY REGISTRAR<br>OCT 24 1983                                   |                                                                    |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1981-1982  
10/10/81  
10/10/81

CHIEF

2000 COTT



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 27731

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                 |                                                                                                                                                             |                                                                        |                                                                                                                                            |                                                                                                                            |                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Edith Claggett Joyce</b>                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                 |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 30, 1983</b>         |                                                                                                                                            | 2b. HOUR<br><b>1:55 AM</b>                                                                                                 |                                                           |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                               | 4. RACE<br><b>Caucasian</b>                                                                                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>February 10, 1907</b>                                                                                              |                                                                        | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.                                                                                          | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |                                                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                            | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                        | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD</b>                                                                       |                                                                                                                            |                                                           |
| 10. CITY OR TOWN OF DEATH<br><b>Chevy Chase</b>                                                                                                                                                                                                                                                                                                                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bethesda Nursing Retirement</b> |                                                                                                                                                             |                                                                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                                                       |                                                           |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                              |                                                                                                                                                 | 13b. COUNTY<br><b>Montgomery</b>                                                                                                                            | 13c. CITY OR TOWN<br><b>Silver Spring</b>                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                            | 13e. STREET ADDRESS<br><b>3501 Forest Edge Dr., #1B</b>                                                                    |                                                           |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frederick Claggett</b>                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                 |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lucretia Young</b> |                                                                                                                                            |                                                                                                                            |                                                           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                     |                                                                                                                                                 | 16b. SOCIAL SECURITY NO.<br><b>579-66-9228</b>                                                                                                              |                                                                        | 17. INFORMANT<br>ADDRESS<br><b>Mr. James W. Joyce, Son,<br/>5004 McCall Street, Rockville, Maryland 20853</b>                              |                                                                                                                            |                                                           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br>2396 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Brain tumor</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>3 weeks</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                                                                                                                                 |                                                                                                                                                             |                                                                        |                                                                                                                                            |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1c</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><b>none</b>                                                                                                                                                                                                                                     |                                                                                                                                                 |                                                                                                                                                             |                                                                        |                                                                                                                                            |                                                                                                                            |                                                           |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                           |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                              |                                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                                                                                                            |                                                           |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                          |                                                                                                                                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                                                                            |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Aug 24, 1983</b> to <b>30 Oct 1983</b> , that (I) (we) lost saw the deceased alive on <b>24 Oct 1983</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                |                                                                                                                                                 |                                                                                                                                                             |                                                                        |                                                                                                                                            |                                                                                                                            |                                                           |
| 22b. SIGNATURE<br><b>Paul T. Noone</b>                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                 | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                        | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                                            | 22c. DATE SIGNED<br><b>30 Oct 83</b>                      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Paul T. Noone, M.D.</b>                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                 | 22e. ADDRESS<br><b>50 W. Edmonston Dr.<br/>Rockville, Maryland 20852</b>                                                                                    |                                                                        |                                                                                                                                            |                                                                                                                            |                                                           |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                      | 23b. DATE<br><b>October 31, 1983</b>                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crematory Alexandria</b>                                                                              |                                                                        | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Virginia</b>                                                                              |                                                                                                                            |                                                           |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey Funeral Homes,<br/>P.A., Bethesda, Maryland</b>                                                                                                                                                                                                                                                                                 |                                                                                                                                                 | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 2 1983</b>                                                                                                           |                                                                        | 25b. REGISTRAR'S SIGNATURE<br><b>John L. Smith</b>                                                                                         |                                                                                                                            |                                                           |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 7 3 2

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                      |                                                                                                                                            |                                           |                                                                                                                            |                                                                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Madeline JUNGHANS</i>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                 | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>10 28 1983</i>               |                                                                                                                                                             |                                                                      | 2b. HOUR<br><i>1:27 P.M.</i>                                                                                                               |                                           |                                                                                                                            |                                                                                                 |  |
| 3. SEX<br><i>Female</i>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><i>Caucasian</i>                                                                                                                     |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>April 6 1898</i>                                                                                                   |                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><i>85</i>                                                                                       |                                           | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 72 HRS.                                                              |                                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Washington, D. C.</i>                                                                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                                   |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.                                                                              |                                           |                                                                                                                            |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><i>Olney</i>                                                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Montgomery General Hospital</i> |                                                                        |                                                                                                                                                             |                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Homemaker</i>                                                       |                                           | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                                                                 |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             | 13b. COUNTY<br><i>Montgomery</i>                                     |                                                                                                                                            | 13c. CITY OR TOWN<br><i>Silver Spring</i> |                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>William Burkley</i>                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Emma Lederer</i> |                                                                                                                                            |                                           |                                                                                                                            |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>                                                                                                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br><i>220-54-1625</i>                                                                                                  |                                                                        | 17. INFORMANT <i>Daughter</i><br>ADDRESS <i>15121 Middlegate Rd. Frances Fitzpatrick Silver Spring, Md. 20904</i>                                           |                                                                      |                                                                                                                                            |                                           |                                                                                                                            |                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><i>4100 Acute myocardial infarction</i><br>IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Arteriosclerotic Heart Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>10 years</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                      |                                                                                                                                            |                                           |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Instantaneous</i>                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                      |                                                                                                                                            |                                           |                                                                                                                            |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                           |                                                                                                                            |                                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                           |                                                                                                                            |                                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>January 1963</i> to <i>October 28, 1983</i> , that (I) (we) lost saw the deceased alive on <i>October 26, 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                      |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                      |                                                                                                                                            |                                           |                                                                                                                            |                                                                                                 |  |
| 22b. SIGNATURE<br><i>Blaine H. Eig</i><br>DEGREE<br><i>M.D.</i>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                      | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                           | 22c. DATE SIGNED<br><i>OCT 29, 1983</i>                                                                                    |                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>BLAINE H. EIG</i>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                      | 22e. ADDRESS<br><i>9801 Georgia Ave Silver Spring Md 20902</i>                                                                             |                                           |                                                                                                                            |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                 | 23b. DATE<br><i>Oct. 31, 1983</i>                                      |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><i>National Memorial Park</i>  |                                                                                                                                            |                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Falls Church Virginia</i>                                                 |                                                                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Francis J. Collins</i>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                      | ADDRESS<br><i>500 University Blvd., W. Silver Spring, Md.</i>                                                                              |                                           | 25. DATE REC'D. BY REGISTRAR<br><i>NOV 2 1983</i>                                                                          |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                      | 26. REGISTRAR'S SIGNATURE<br><i>John J. Lough</i>                                                                                          |                                           |                                                                                                                            |                                                                                                 |  |

MEDICAL CERTIFICATION

www

ONLY:

800-460-7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

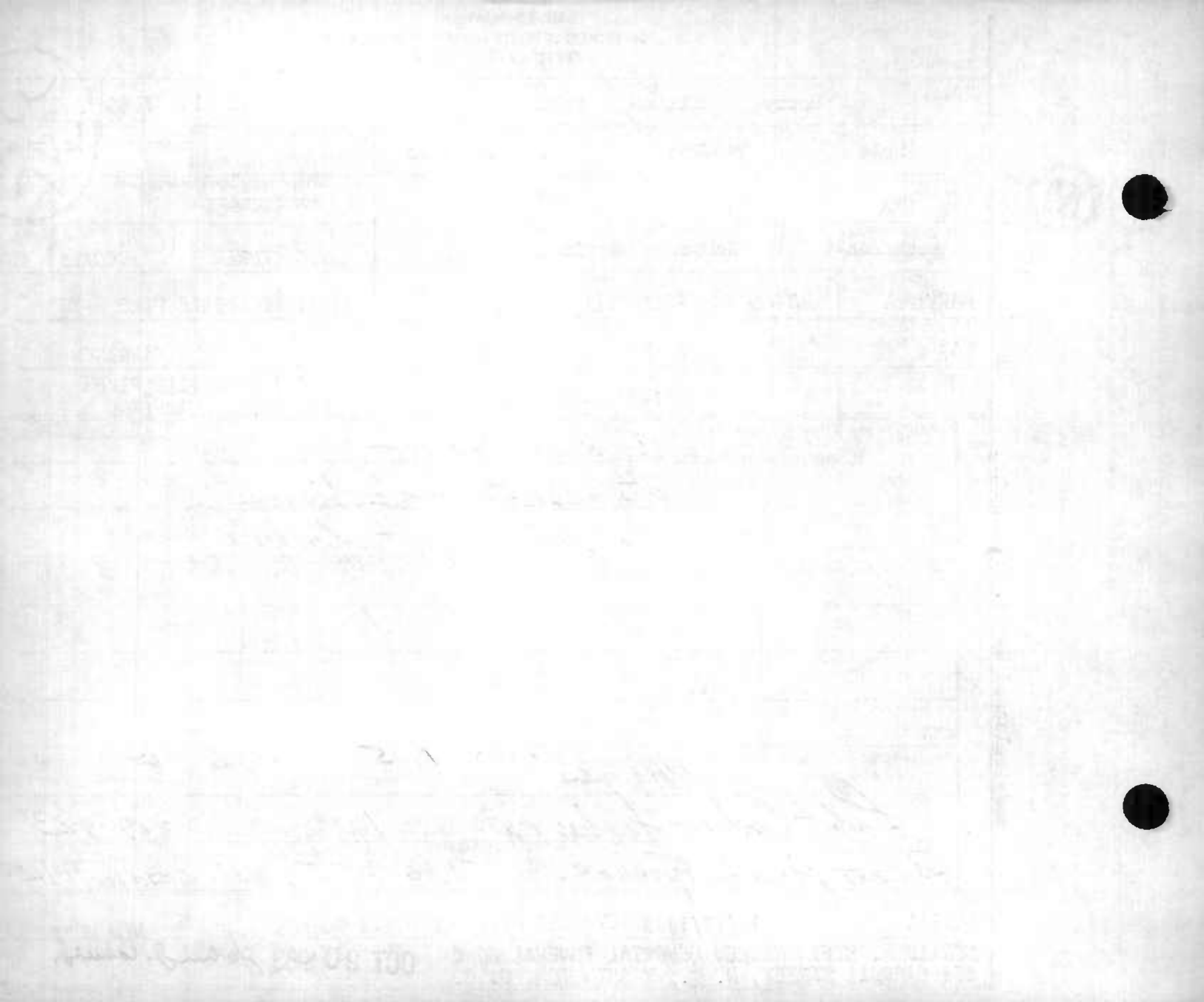
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is not, a gun injury, or other traumatic event, the medical examiner must be notified.

Body released by Dr. Mayle, M.E.

# MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                |  |                                                                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  | REG. NO. 83 27133 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|-------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                |  |                                                                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  |                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Harry William Kahn                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                |  |                                                                                                                                                              |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 14 1983                                                  |  | 2b. HOUR<br>3:27P M                                                                                                        |  |                   |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br>WHITE                                                                                                               |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>7 29 1905                                                                                                                 |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS                                                       |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                                 |  |                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW YORK                                                                                                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                         |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                                          |  |                                                                                                                            |  |                   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda                                                                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  |                                                                                                                                                              |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MANUFACTURER                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>RAINCOATS                                                                             |  |                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>MARYLAND MONTGOMERY ROCKVILLE                                                                                                                                                                                                                                                                  |  |                                                                                                                                |  |                                                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>10811 ROCKVILLE PIKE 20852                                                                          |  |                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>MAX COHEN                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ANNIE HARRISON                                                                                                 |  |                                                                                                 |  |                                                                                                                            |  |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(S, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                                                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br>091-07-9483                                                                                        |  | 17. INFORMANT ADDRESS<br>IDA JANE KAHN, 10811 ROCKVILLE PIKE, ROCKVILLE, MARYLAND                                                                            |  |                                                                                                 |  |                                                                                                                            |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Arteriosclerotic heart disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>Congestive heart failure</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                |  |                                                                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                |  |                                                                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  |                   |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                               |  |                                                                                                                                                              |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                                |  |                                                                                                 |  |                                                                                                                            |  |                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                            |  |                                                                                                 |  |                                                                                                                            |  |                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/13</u> 19 <u>83</u> , to <u>10/13</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>10/13</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                            |  |                                                                                                                                |  |                                                                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  |                   |  |
| 22b. SIGNATURE<br><u>Robert Andrew Fischer</u>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                |  | DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                                                                                                 |  | 22c. DATE SIGNED<br><u>10/14/83</u>                                                                                        |  |                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>ROBERT ANDREW FISCHER</u>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                |  | 22e. ADDRESS<br><u>730 24th ST., N.W., WASHINGTON D.C.</u>                                                                                                   |  |                                                                                                 |  |                                                                                                                            |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br>10/17/1983                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CYPRESS HILLS CEMETERY                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>QUEENS NEW YORK                                   |  |                                                                                                                            |  |                   |  |
| 24. FUNERAL DIRECTOR<br>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME<br>232 CARROLL STREET, N. W., WASHINGTON, D. C.                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                |  |                                                                                                                                                              |  | 25. DATE REC'D BY REGISTRAR<br>OCT 20 1983 REGISTRAR'S SIGNATURE <u>John J. Smith</u>           |  |                                                                                                                            |  |                   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 1 3 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |                                                               |                                                                                                                                                          |  |                                                                                                                         |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Edna W. Keller</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                        | 2a. DATE OF DEATH MONTH <u>10</u> DAY <u>9</u> YEAR <u>83</u> |                                                                                                                                                          |  | 2b. HOUR <u>12</u> <u>AM</u>                                                                                            |  |
| 3. SEX <u>Female</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE <u>Cau</u>                                                                                                                     |                                                               | 5. DATE OF BIRTH MONTH <u>7</u> DAY <u>17</u> YEAR <u>1886</u>                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>97</u> YRS.                                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Spencer W. Va.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                                                                             |                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.                                                              |  |
| 10. CITY OR TOWN OF DEATH <u>Rockville</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Collingswood N.C. Center</u> |                                                               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u>                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>                                                                       |  |
| 13a. CITY OR TOWN <u>Washington D.C.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                        |                                                               | 13b. STREET ADDRESS <u>4201 Butterworth Pl. N.W.</u>                                                                                                     |  | 13c. ZIP CODE <u>20016</u>                                                                                              |  |
| 14. FATHER'S NAME FIRST <u>Abraham</u> MIDDLE <u></u> LAST <u>Wells</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME FIRST <u>Leona</u> MIDDLE <u></u> LAST <u>McMoth</u>                                                          |                                                               |                                                                                                                                                          |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <u>No</u>                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO. <u>234-12-4497D</u>                                                                                           |                                                               | 17. INFORMANT <u>Mary B. Keller</u> ADDRESS <u>4720 Chevy Chase Dr. Maryland</u>                                                                         |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4140 Congestive heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Advanced cerebral arteriosclerosis with CBS.</u> |  |                                                                                                                                        |                                                               |                                                                                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>24 hrs</u><br><u>10 yrs</u><br><u>10 yrs</u>                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |                                                               | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                   |                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                    |                                                               | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 10</u> 19 <u>82</u> to <u>Oct 9</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Oct 5</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.                                                                                                                                                              |  |                                                                                                                                        |                                                               |                                                                                                                                                          |  |                                                                                                                         |  |
| 22b. SIGNATURE <u>James R. Moore Jr.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                        |                                                               | DEGREE <u>MD</u>                                                                                                                                         |  | 22c. DATE SIGNED <u>10-10-83</u>                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>James R. Moore Jr.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |                                                               | 22e. ADDRESS <u>207 Brooker Ave Gaithersburg Md.</u>                                                                                                     |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE <u>Oct. 11, 1983</u>                                                                                                         |                                                               | 23c. NAME OF CEMETERY OR CREMATORY <u>Metropolitan Crematory Alexandria, Virginia</u>                                                                    |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                 |  |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND</u>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        |                                                               | 25a. DATE RECORDED BY REGISTRAR <u>Oct 13 1983</u> REGISTRAR'S SIGNATURE <u>[Signature]</u>                                                              |  |                                                                                                                         |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                              |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             | 8 3 2 7 7 3 5                                                                         |                                                                                                                                            |                                                                     |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             | REG. NO.                                                                              |                                                                                                                                            |                                                                     |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>OLIVE P. KERBY</u>                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>10-19-83</u>                                |                                                                                                                                            |                                                                     | 2b. HOUR<br><u>9:15</u> M                                                                                                  |  |
| 3. SEX<br><u>Female</u>                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br><u>White</u>                                                                                                                         |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>April 20, 1903</u>                                                                                                 |                                                                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>80</u> YRS.                                                                                          |                                                                     | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Maryland</u>                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                                                      |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Montgomery</u> MD.                                                                              |                                                                     |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><u>Gaithersburg</u>                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Herman Wilson Health Center</u> |                                                                        |                                                                                                                                                             |                                                                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Ret-Teacher</u>                                                     |                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>P.G. Schools</u>                                                                   |  |
| 13a. STATE<br><u>Maryland</u>                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY<br><u>PG</u>                                                                                                                        |                                                                        | 13c. CITY OR TOWN<br><u>Suitland</u>                                                                                                                        |                                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                            |                                                                     | 13e. STREET ADDRESS<br><u>Lubbock Street 20746</u>                                                                         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Ralph A. Payne, Sr.</u>                                                                                                                                                                                                                                                                      |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Lillian M. Allen</u>              |                                                                                                                                            |                                                                     |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>No</u>                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br><u>213-38-1545</u>                                                                                                  |                                                                        | 17. INFORMANT<br><u>Brother</u>                                                                                                                             |                                                                                       | ADDRESS<br><u>2605 Holly Drive Fort Washington, Md</u>                                                                                     |                                                                     |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>3320</u> IMMEDIATE CAUSE (a) <u>Acute bronchitis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Parkinsonism</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Cerebral arteriosclerosis</u>                               |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>40</u><br><u>5yr</u><br><u>5yr</u> |                                                                                                                                            |                                                                     |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                      |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                                       |                                                                                                                                            |                                                                     |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |                                                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                  |  |                                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)                                                             |                                                                     |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                              |  |                                                                                                                                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                     |                                                                                                                            |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>June 3, 1982</u> to <u>Oct 19, 1983</u> , that (1) (we) last saw the deceased alive on <u>Oct 1, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                                       |                                                                                                                                            |                                                                     |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>James R. Moore Jr.</u>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                 | DEGREE<br><u>MD</u>                                                    |                                                                                                                                                             |                                                                                       | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                     | 22c. DATE SIGNED<br><u>10-19-83</u>                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                 | 22e. ADDRESS<br><u>207 Brookes Ave Gaithersburg Md.</u>                |                                                                                                                                                             |                                                                                       |                                                                                                                                            |                                                                     |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>                                                                                                                                                                                                                                                                             |  |                                                                                                                                                 | 23b. DATE<br><u>10-22-83</u>                                           |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Cemetery</u>                      |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Suitland PG Md</u> |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Robert E. Wilhelm Funeral Home</u>                                                                                                                                                                                                                                                                     |  |                                                                                                                                                 | ADDRESS<br><u>Suitland, Md</u>                                         |                                                                                                                                                             | DATE REC'D BY REGISTRAR<br><u>OCT 24 1983</u>                                         |                                                                                                                                            | REGISTRAR'S SIGNATURE<br><u>James R. Moore Jr.</u>                  |                                                                                                                            |  |

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Refused.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 1 3 6

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|                                                                    |                                                                                                                                         |                                                                                                                                                             |                                                                                      |                                                                                   |                                                        |                           |  |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|--------------------------------------------------------|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Dorothy Jeanette Kernan</i> |                                                                                                                                         |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>10 - 9 - 83</i>                            |                                                                                   |                                                        | 2b. HOUR<br><i>6:15 P</i> |  |
| 3. SEX<br><i>Female</i>                                            | 4. RACE<br><i>Caucasian</i>                                                                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Aug. 25, 1909</i>                                                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>74</i> YRS.                                    |                                                                                   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.              |                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Minn.</i>          | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.                     |                                                        |                           |  |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Holy Cross Hospital</i> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Homemaker</i> |                                                                                   | 12b. KIND OF BUSINESS OR INDUSTRY                      |                           |  |
| 13a. STATE<br><i>Maryland</i>                                      |                                                                                                                                         |                                                                                                                                                             | 13b. COUNTY<br><i>Montgomery</i>                                                     | 13c. CITY OR TOWN<br><i>Silver Spring</i>                                         | 13d. STREET ADDRESS<br><i>1814 Snowdrop Lane 20906</i> |                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Axel Burns</i>        |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Carolyn Streid</i>                                                                                      |                                                                                      | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i> |                                                        |                           |  |
| 16b. SOCIAL SECURITY NO.<br><i>471-09-8350</i>                     |                                                                                                                                         | 17. INFORMANT<br>ADDRESS<br><i>Mrs. Margaret K. Hertz-Daughter 1814 Snowdrop Lane S.S., Md. 20906</i>                                                       |                                                                                      |                                                                                   |                                                        |                           |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4912

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) *CHRONIC OBSTRUCTIVE Pulmonary Disease*

DUE TO, OR AS A CONSEQUENCE OF

(c) *CHRONIC BRONCHITIS*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

*Seizure Disorder*

|                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                               |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                          |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 6</i> , 19 <i>83</i> , to <i>Oct 9</i> , 19 <i>83</i> , that (I) (we) lost<br>saw the deceased alive on <i>Oct 9</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><i>Bernard A. Fitzgerald</i>                                                                                                                                                                                                                                                                                                                              |  | DEGREE<br><i>MD</i>                                                    |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>10/9/83</i>                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>BERNARD A. FITZGERALD</i>                                                                                                                                                                                                                                                                                                       |  |                                                                        |  | 22e. ADDRESS<br><i>217 UNIVERSITY BLVD E, SILVER SPRING MD</i>                                                                             |  |                                                                                                                               |  |

|                                                               |                                   |                                                               |                                                                     |
|---------------------------------------------------------------|-----------------------------------|---------------------------------------------------------------|---------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i> | 23b. DATE<br><i>Oct. 13, 1983</i> | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Calvary Cemetery</i> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Red Wing Minn.</i> |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Francis J. Collins</i>     |                                   | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 13 1983</i>           | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connelley</i>              |
| 500 University Blvd. W. Silver Spring, Maryland               |                                   |                                                               |                                                                     |

1912 10 2 11



George Barker  
Charles Barker  
Charles Barker  
Charles Barker

For a list of names

George A. Barker  
George A. Barker  
George A. Barker  
George A. Barker



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, THE MEDICAL DIRECTOR MUST BE NOTIFIED BY TELEPHONE. PAGES 1, 2, AND 3 TO THIS CERTIFICATE SHOULD BE FILED WITH THE MEDICAL EXAMINER'S FILES. PAGES 4 AND 5 SHOULD BE FILED WITH THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRISTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR MOVAL.

BP\_\_\_\_\_

DHMH - 17

(VR A15 ME (5))

20M 4/82

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                         |  |                                                   |  |                                                          |  |                                                    |  |                     |  |                                                                     |  |                                              |  |                               |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------|--|---------------------------------------------------|--|----------------------------------------------------------|--|----------------------------------------------------|--|---------------------|--|---------------------------------------------------------------------|--|----------------------------------------------|--|-------------------------------|--|--|--|
| 1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                     |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE |  |                                                   |  |                                                          |  |                                                    |  |                     |  | 27731                                                               |  |                                              |  |                               |  |  |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                |  |                                         |  |                                                   |  |                                                          |  |                                                    |  |                     |  |                                                                     |  | REG. NO.                                     |  |                               |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                         |  |                                                   |  | 2a. DATE KNOWN OF DEATH                                  |  |                                                    |  |                     |  | 2b. HOUR                                                            |  |                                              |  |                               |  |  |  |
| Ernest V. Kibler                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                         |  |                                                   |  | Oct 31, 1983                                             |  |                                                    |  |                     |  | 11:50 M                                                             |  |                                              |  |                               |  |  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE                                 |  | 5. DATE OF BIRTH                                  |  | 6. AGE                                                   |  | 7. IF UNDER 1 YR.                                  |  | 8. IF UNDER 24 HRS. |  | 9. DATE PRONOUNCED DEAD                                             |  | 10. HOUR                                     |  |                               |  |  |  |
| M                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | W                                       |  | Feb. 25, 1905                                     |  | 58 YRS.                                                  |  | MONTHS                                             |  | DAYS                |  | HOURS                                                               |  | MIN.                                         |  |                               |  |  |  |
| 7a. BIRTHPLACE                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                         |  | 7b. CITIZEN OF WHAT COUNTRY?                      |  |                                                          |  | 8. MARRIED                                         |  |                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                              |  |                               |  |  |  |
| Tenn.                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                         |  | U. S. A.                                          |  |                                                          |  | WIDOWED                                            |  |                     |  | Montgomery MD                                                       |  |                                              |  |                               |  |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                         |  |                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  |                                                    |  |                     |  | 12a. USUAL OCCUPATION                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |                               |  |  |  |
| Pittsbg                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                         |  |                                                   |  | Holy Cross Hosp                                          |  |                                                    |  |                     |  | Safeway: Prod. Mgr.                                                 |  | Retired.                                     |  |                               |  |  |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                         |  |                                                   |  | 13b. COUNTY                                              |  |                                                    |  |                     |  | 13c. CITY OR TOWN                                                   |  | 13d. INSIDE CITY LIMITS?                     |  | 13e. STREET ADDRESS           |  |  |  |
| Md                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                         |  |                                                   |  | Mont.                                                    |  |                                                    |  |                     |  | Pittsbg                                                             |  | YES                                          |  | 1321 Ewood Lane               |  |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                         |  |                                                   |  | 15. MOTHER'S MAIDEN NAME                                 |  |                                                    |  |                     |  | 16. ADDRESS                                                         |  |                                              |  |                               |  |  |  |
| William Kibler.                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                         |  |                                                   |  | Lucy Givens.                                             |  |                                                    |  |                     |  |                                                                     |  |                                              |  |                               |  |  |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                                                                                                                                                                                                                                                                                                                                                                           |  |                                         |  |                                                   |  | 17b. SOCIAL SECURITY NO.                                 |  |                                                    |  |                     |  | 17c. INFORMANT                                                      |  |                                              |  | 17d. ADDRESS                  |  |  |  |
| No.                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                         |  |                                                   |  | 577-05-1766                                              |  |                                                    |  |                     |  | Virginia W. Kibler.                                                 |  |                                              |  | (Wife) 13e                    |  |  |  |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                         |  |                                                   |  |                                                          |  |                                                    |  |                     |  |                                                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                               |  |  |  |
| PART I DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                         |  |                                                   |  |                                                          |  |                                                    |  |                     |  |                                                                     |  | 1 day                                        |  |                               |  |  |  |
| IMMEDIATE CAUSE (a) Sudden myocardial Dis                                                                                                                                                                                                                                                                                                                                                                                              |  |                                         |  |                                                   |  |                                                          |  |                                                    |  |                     |  |                                                                     |  |                                              |  |                               |  |  |  |
| 4291                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                         |  |                                                   |  |                                                          |  |                                                    |  |                     |  |                                                                     |  |                                              |  |                               |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                         |  |                                                   |  |                                                          |  |                                                    |  |                     |  |                                                                     |  |                                              |  |                               |  |  |  |
| (b)                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                         |  |                                                   |  |                                                          |  |                                                    |  |                     |  |                                                                     |  |                                              |  |                               |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                         |  |                                                   |  |                                                          |  |                                                    |  |                     |  |                                                                     |  |                                              |  |                               |  |  |  |
| (c)                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                         |  |                                                   |  |                                                          |  |                                                    |  |                     |  |                                                                     |  |                                              |  |                               |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                                                                                                    |  |                                         |  |                                                   |  |                                                          |  |                                                    |  |                     |  |                                                                     |  |                                              |  |                               |  |  |  |
| None                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                         |  |                                                   |  |                                                          |  |                                                    |  |                     |  |                                                                     |  |                                              |  |                               |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? |  |                                                          |  |                                                    |  |                     |  | 20. AUTOPSY?                                                        |  |                                              |  |                               |  |  |  |
| None                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                         |  |                                                   |  |                                                          |  |                                                    |  |                     |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                              |  |                               |  |  |  |
| 21a. EXTERNAL CAUSE WAS                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                         |  | 21b. TIME OF INJURY                               |  |                                                          |  | 21c. HOW INJURY OCCURRED                           |  |                     |  |                                                                     |  |                                              |  |                               |  |  |  |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                            |  |                                         |  | HOUR A.M. MONTH DAY YEAR                          |  |                                                          |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 |  |                     |  |                                                                     |  |                                              |  |                               |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                         |  | P.M. 19                                           |  |                                                          |  |                                                    |  |                     |  |                                                                     |  |                                              |  |                               |  |  |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                         |  | 21e. PLACE OF INJURY                              |  |                                                          |  | 21f. LOCATION                                      |  |                     |  |                                                                     |  |                                              |  |                               |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                    |  |                                         |  | STREET, FACTORY, FARM, ETC.)                      |  |                                                          |  | STREET CITY OR TOWN COUNTY STATE                   |  |                     |  |                                                                     |  |                                              |  |                               |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                         |  |                                                   |  |                                                          |  |                                                    |  |                     |  |                                                                     |  |                                              |  |                               |  |  |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                         |  | TITLE (SPECIFY)                                   |  |                                                          |  | M.D.                                               |  |                     |  | MEDICAL EXAMINER                                                    |  |                                              |  | DATE SIGNED                   |  |  |  |
| John P. Rogers                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                         |  | Waf                                               |  |                                                          |  |                                                    |  |                     |  |                                                                     |  |                                              |  | Oct 31, 1983                  |  |  |  |
| EXAMINER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                         |  | ADDRESS                                           |  |                                                          |  |                                                    |  |                     |  |                                                                     |  |                                              |  |                               |  |  |  |
| (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                         |  |                                                   |  |                                                          |  |                                                    |  |                     |  |                                                                     |  |                                              |  |                               |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                         |  | 23b. DATE                                         |  |                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY                 |  |                     |  | 23d. LOCATION                                                       |  |                                              |  | 23e. DATE REC'D. BY REGISTRAR |  |  |  |
| (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                         |  |                                                   |  |                                                          |  |                                                    |  |                     |  | CITY OR TOWN COUNTY STATE                                           |  |                                              |  | DATE REGISTRAR'S SIGNATURE    |  |  |  |
| Burial.                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                         |  | Nov. 4, 1983                                      |  |                                                          |  | Union Cemetery, Burtonsville, Montg. Md.           |  |                     |  |                                                                     |  |                                              |  |                               |  |  |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                         |  | 25. DATE                                          |  |                                                          |  | 26. NAME OF CEMETERY OR CREMATORY                  |  |                     |  | 27. ADDRESS                                                         |  |                                              |  | 28. SIGNATURE                 |  |  |  |
| Takoma Funeral Home                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                         |  | NOV 02 1983                                       |  |                                                          |  | 254 Carroll St. N. W. D. C.                        |  |                     |  |                                                                     |  |                                              |  | John J. Gough                 |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                |                                                                                                                                                          |                                                                                                                                   | 8 3 2 7 1 3 8                                                                                                   |                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                |                                                                                                                                                          |                                                                                                                                   | REG. NO.                                                                                                        |                                              |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHRISTOPHER JOSEPH KIMENER</b>                                                                                                                                                                                                                                                                                                              |                                                                                                                                                |                                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 8 1983</b>                                                                      |                                                                                                                 | 2b. HOUR<br><b>9:00a M</b>                   |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE<br><b>CAUCASIAN</b>                                                                                                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JULY 4 1983</b>                                                                                                 |                                                                                                                                   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.<br><b>YRS. 3 4</b> |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                          | 7b. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>                                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY MD</b>                                                    |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>                                                                                                                                                                                                                                                                                                                                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NAVAL HOSPITAL BETHESDA MD</b> |                                                                                                                                                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                  |                                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY            |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                               |                                                                                                                                                |                                                                                                                                                          | 13e. STREET ADDRESS                                                                                                               |                                                                                                                 |                                              |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                         | 13b. COUNTY<br><b>MONTGOMERY</b>                                                                                                               | 13c. CITY OR TOWN<br><b>BETHESDA</b>                                                                                                                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><b>NAVAL HOSPITAL BETHESDA</b> |                                                                                                                 |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MICHAEL JAMES KIMENER</b>                                                                                                                                                                                                                                                                                                                |                                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LORRAINE CECILA MRUZ</b>                                                                             |                                                                                                                                   |                                                                                                                 |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NA</b>                                                                                                                                                                                                                                                                         |                                                                                                                                                | 16b. SOCIAL SECURITY NO.                                                                                                                                 |                                                                                                                                   | 17. INFORMANT ADDRESS<br><b>MICHAEL KIMENER, 2112 TURNBERRY COVE, VIRGINIA BEACH, VA 23454</b>                  |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PREMATURITY COMPLICATED BY HEPATITIS &amp; SEPSIS</b><br>7650 DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ |                                                                                                                                                |                                                                                                                                                          |                                                                                                                                   |                                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____                                                                                                                                                                                                                                             |                                                                                                                                                |                                                                                                                                                          |                                                                                                                                   |                                                                                                                 |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                                                                                                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |                                              |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                            |                                                                                                                                                |                                                                                                                                                          |                                                                                                                                   |                                                                                                                 |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                 |                                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                               |                                                                                                                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                  |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                          |                                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                   |                                                                                                                                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                               |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 4</b> , 19 <b>83</b> , to <b>OCTOBER 8</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>OCTOBER 8</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.        |                                                                                                                                                |                                                                                                                                                          |                                                                                                                                   |                                                                                                                 |                                              |
| 22b. SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                | DEGREE                                                                                                                                                   |                                                                                                                                   | 22c. DATE SIGNED<br><b>9 Oct '83</b>                                                                            |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>I.M. GLADSTONE, LT, MC, USNR</b>                                                                                                                                                                                                                                                                                                          |                                                                                                                                                | 22e. ADDRESS<br><b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND NATIONAL CAPITAL REGION, BETHESDA MD 20814</b>                                                  |                                                                                                                                   |                                                                                                                 |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                | 23b. DATE<br><b>10/12/83</b>                                                                                                                             |                                                                                                                                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>                                                 |                                              |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Arlington, VA</b>                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                |                                                                                                                                                          |                                                                                                                                   |                                                                                                                 |                                              |
| 24. FUNERAL DIRECTOR NAME<br><b>Murphy Funeral Home</b>                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                | 4510 Wilson Blvd. Arlington VA                                                                                                                           |                                                                                                                                   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 17 1983</b>                                                             |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                |                                                                                                                                                          |                                                                                                                                   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                |                                              |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Page 1, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                    |  |                                                                                                                                |  | REG. NO. 8 3 2 7 7 3 9                                                                                                                                   |  |                                                                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR A.M.                                                                                                           |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Cordelia Elizabeth King                                                                                                                                                                                                                                                              |  |                                                                                                                                |  | October 4 1883 6:30 M                                                                                                                                    |  |                                                                                                                         |  |
| 3. SEX Female                                                                                                                                                                                                                                                                                                                           |  | 4. RACE White                                                                                                                  |  | 5. DATE OF BIRTH MONTH DAY YEAR June 4 1899                                                                                                              |  | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Gaithersburg                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                            |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.                                                                     |  |
| 10. CITY OR TOWN OF DEATH Gaithersburg                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 16100 So. Frederick Rd. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife                                                                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.                                                                                                                                                                                                                             |  | 13b. COUNTY Montgomery                                                                                                         |  | 13c. CITY OR TOWN Gaithersburg                                                                                                                           |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas I. Fulks                                                                                                                                                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Lois Williams                                                                |  | 13e. STREET ADDRESS 16100 South Frederick Rd.                                                                                                            |  | 20877                                                                                                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO. -                                                                                                     |  | 17. INFORMANT ADDRESS Elizabeth Jean Jacobs Gaithersburg, Md. 20877                                                                                      |  | 1 Central Ave.,                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4292 Heart Failure<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Altho sclerotic Cardio-Vascular Disease<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |                                                                                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                             |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. No                                                                                                                                                                                                  |  |                                                                                                                                |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                               |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                           |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                            |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/25/83 June 19 65 to 10/4/83, that (I) (we) last saw the deceased alive on 9/25/83 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.                    |  |                                                                                                                                |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 22b. SIGNATURE James L. Hooper                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                |  | DEGREE                                                                                                                                                   |  | 22c. DATE SIGNED 10/4/83                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES L. HOOPER M.D.                                                                                                                                                                                                                                                                              |  |                                                                                                                                |  | 22e. ADDRESS 1515 E. DEER PARK DR. GAITHERSBURG, MD 20877                                                                                                |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial                                                                                                                                                                                                                                                                                        |  | 23b. DATE 10/6/83                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery                                                                                                   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Fred. Md.                                                             |  |
| 24. FUNERAL DIRECTOR G. H. Sandison 316 E. Diamond Ave., Gaithersburg, Md. 20877                                                                                                                                                                                                                                                        |  |                                                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR OCT 10 1983                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE                                                                                              |  |

BP

RECEIVED  
JAN 10 1970



RECEIVED  
JAN 10 1970

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[Several lines of faint, illegible text follow, possibly a memorandum format.]

CHILE

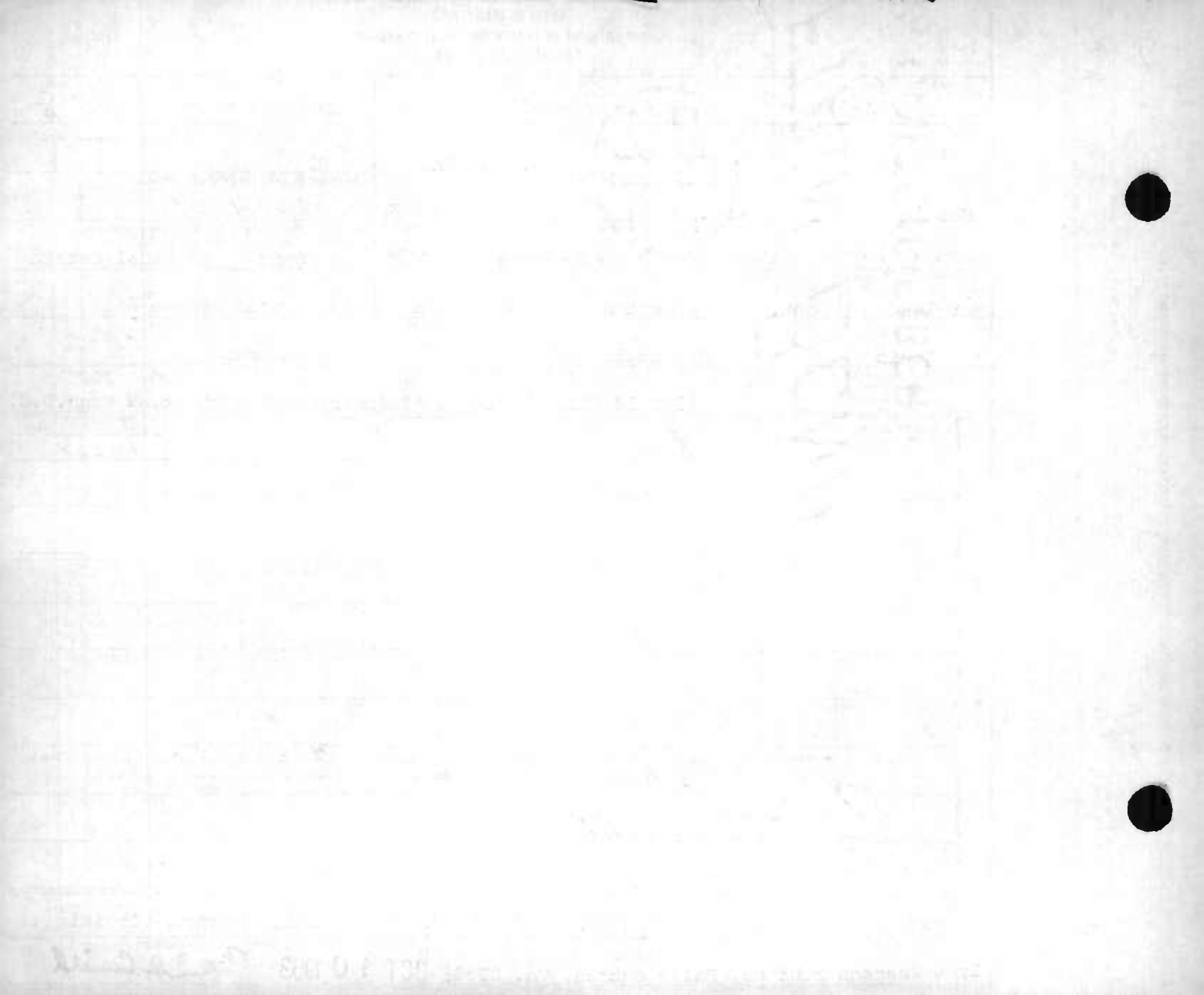


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                       |  |                                                                                                                                                          |                                                                                                                                                   |                                                                            |                                                  |                                                                                                                         |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                       |  |                                                                                                                                                          | REG. NO.                                                                                                                                          |                                                                            |                                                  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>HELEN KLEIMANN</b>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                       |  |                                                                                                                                                          | 2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 4 1983</b> 2b. HOUR <b>5:05 A</b> M                                                                   |                                                                            |                                                  |                                                                                                                         |  |
| 3 SEX <b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | 4 RACE <b>CAUCASIAN</b>                                                                                                               |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 18 1891</b>                                                                                                      |                                                                                                                                                   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS                              |                                                  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Russia</b>                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>                                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                                                                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.                 |                                                  |                                                                                                                         |  |
| 10. CITY OR TOWN OF DEATH <b>WHEATON</b>                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIVERSITY NURSING HOME</b> |  |                                                                                                                                                          |                                                                                                                                                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Agent</b> |                                                  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>                                                                    |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                       |  |                                                                                                                                                          | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                      |                                                                            |                                                  |                                                                                                                         |  |
| 13a. STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY <b>Mont.</b>                                                                                                              |  | 13c. CITY OR TOWN <b>Wheaton</b>                                                                                                                         |                                                                                                                                                   | 13e. STREET ADDRESS <b>901 Arcola Avenue</b> <b>20902</b>                  |                                                  |                                                                                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Louis Weinstein</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                       |  |                                                                                                                                                          | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>                                                                                         |                                                                            |                                                  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO. <b>132 14 0135</b>                                                                                           |  | 17. INFORMANT ADDRESS <b>20007 Jack H. Kleinmann-2822 39th St. NW Wash. D.C.</b>                                                                         |                                                                                                                                                   |                                                                            |                                                  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEPSIS</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                                       |  |                                                                                                                                                          |                                                                                                                                                   |                                                                            |                                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK.</b>                                                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____                                                                                                                                                                                                                                                             |  |                                                                                                                                       |  |                                                                                                                                                          |                                                                                                                                                   |                                                                            |                                                  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |  |                                                                                                                                                          |                                                                                                                                                   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>     |                                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |                                                                                                                                                   |                                                                            |                                                  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                                                                   |                                                                            |                                                  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/16/83</b> , 19 <b>83</b> , to <b>4 OCTOBER 83</b> , that (I) <del>last</del> saw the deceased alive on <b>3 OCTOBER 83</b> , and that in (my) <del>my</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did not</del> view the body after death.                                   |  |                                                                                                                                       |  |                                                                                                                                                          |                                                                                                                                                   |                                                                            |                                                  |                                                                                                                         |  |
| 22b. SIGNATURE <b>Walter Goetz</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |  |                                                                                                                                                          | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                            |                                                  | 22c. DATE SIGNED                                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WALTER GOETZ M.D.</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                       |  |                                                                                                                                                          | 22e. ADDRESS <b>2309 SNORFIELD RD - WHEATON, MD -</b>                                                                                             |                                                                            |                                                  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE <b>Oct 5, 1983</b>                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY <b>King David Cemetery</b>                                                                                            |                                                                                                                                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Falls Church, Virginia</b>      |                                                  |                                                                                                                         |  |
| 24. FUNERAL DIRECTOR NAME <b>Ives-Pearson F. Homes, Falls Church, Va. 22046</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       |  |                                                                                                                                                          | 25a. DATE REC'D. BY REGISTRAR <b>OCT 10 1983</b>                                                                                                  |                                                                            | 25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b> |                                                                                                                         |  |

BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                            |                                                                         |                                                                                                                                                             |                                                                                         |                                                                                                                                            |                                                                                                 |                                                                                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Marion Duffel Fisler Bozarth Kolbye</b>                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                            | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>October 20, 1983</b>             |                                                                                                                                                             |                                                                                         | 2b. HOUR<br><b>10:30P M</b>                                                                                                                |                                                                                                 |                                                                                                                                     |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>Caucasian</b>                                                                                                                |                                                                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 31, 1903</b>                                                                                                |                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS                                                                                           |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                                     |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                       |                                                                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD</b>                                                                       |                                                                                                 |                                                                                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4802 Fort Sumner Drive</b> |                                                                         |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Physician</b>    |                                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Gynecology</b>                                          |                                                                                                                                     |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                            | 13b. COUNTY<br><b>Montgomery</b>                                        |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Bethesda</b>                                                    |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>A. J. Bozarth</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edith Fisler</b>    |                                                                                                                                                             |                                                                                         | 13e. STREET ADDRESS (zip: 20816)<br><b>4802 Fort Sumner Drive</b>                                                                          |                                                                                                 |                                                                                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                            | 16b. SOCIAL SECURITY NO.<br><b>139-34-3132</b>                          |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>Albert C. Kolbye, Jr., M.D., Son</b><br>Same as item #13 |                                                                                                                                            |                                                                                                 |                                                                                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pulmonary Metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Carcinoma of the Breast</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>one week</b><br><b>1 yr</b><br><b>1 yr</b> |  |                                                                                                                                            |                                                                         |                                                                                                                                                             |                                                                                         |                                                                                                                                            |                                                                                                 | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |                                                                                                                                                             |                                                                                         | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                       |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)          |                                                                                                                                            |                                                                                                 |                                                                                                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                            | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |                                                                                                                                            |                                                                                                 |                                                                                                                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-12</b> , 19 <b>83</b> , to <b>10-20</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>9-14</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                                                             |  |                                                                                                                                            |                                                                         |                                                                                                                                                             |                                                                                         |                                                                                                                                            |                                                                                                 |                                                                                                                                     |  |
| 22b. SIGNATURE<br><b>Frederick D Barr M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                            | DEGREE<br><b>M.D.</b>                                                   |                                                                                                                                                             |                                                                                         | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br><b>Oct. 21, 1983</b>                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Frederick Barr, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                            | 22e. ADDRESS<br><b>5454 Wisconsin Ave., Chevy Chase, Maryland 20815</b> |                                                                                                                                                             |                                                                                         |                                                                                                                                            |                                                                                                 |                                                                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                            | 23b. DATE<br><b>Oct. 22, 1983</b>                                       |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crematory</b>                     |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Alexandria Virginia</b>                        |                                                                                                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                            | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 25 1983</b>                     |                                                                                                                                                             |                                                                                         | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                                                                                        |                                                                                                 |                                                                                                                                     |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                        |  |                                                                             |  | REG. NO.                                                                                                                                                 |  |                                                                                                                         |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                      |  |                                                                             |  | 26. DATE OF DEATH MONTH DAY YEAR 26 HOUR                                                                                                                 |  |                                                                                                                         |  |
| 1. DECEASED NAME FIRST MIDDLE LAST Rhoda Kreiel                                                                                                                                                                                                                                                             |  |                                                                             |  | 10/11/83 11 59 P.M.                                                                                                                                      |  |                                                                                                                         |  |
| 3. SEX Female                                                                                                                                                                                                                                                                                               |  | 4. RACE Caucasian                                                           |  | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 10, 1921                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. MONTHS DAYS HOURS MIN                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN) New York                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY? United States                                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.                                                                     |  |
| 10. CITY OR TOWN OF DEATH Bethesda                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 8714 Hartsdale Ave. |  | 12a. USUAL OCCUPATION Bus. Administrator                                                                                                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY High School                                                                           |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Bethesda                                                                                                                                           |  |                                                                             |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 8714 Hartsdale Ave. 20817               |  |                                                                                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Arthur Adler                                                                                                                                                                                                                                                            |  |                                                                             |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Jacoby                                                                                                 |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO. N/A 067 16 0943                                    |  | 17. INFORMANT ADDRESS Robert A. Kreiel, husband, same as #13                                                                                             |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure 2000 DUE TO, OR AS A CONSEQUENCE OF (b) Histocytic Lymphoma 9 months DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes |  |                                                                             |  |                                                                                                                                                          |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 6                                                                                                                                                                          |  |                                                                             |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                          |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                    |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)         |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 6/82 to 10/11/83, that (I) (we) lost saw the deceased alive on 10/8/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                |  |                                                                             |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 22b. SIGNATURE John S. MacDonald MD                                                                                                                                                                                                                                                                         |  |                                                                             |  | 22c. DATE SIGNED 10/12/83                                                                                                                                |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. John McDonald                                                                 |  |
| 22e. ADDRESS 5401 Western Ave., Chevy Chase, Md. 20015                                                                                                                                                                                                                                                      |  |                                                                             |  | 22f. NAME OF CEMETERY OR CREMATORY King David Mem. FR. Falls Church, Va.                                                                                 |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL Oct. 14, 1983                                                                                                                                                                                                                                                               |  |                                                                             |  | 23b. DATE 10/14/83                                                                                                                                       |  |                                                                                                                         |  |
| 24. FUNERAL DIRECTOR Ives Pearson Funeral Home Falls Church, Va. 22046                                                                                                                                                                                                                                      |  |                                                                             |  | 25a. DATE REC'D. BY REGISTRAR OCT 17 1983                                                                                                                |  |                                                                                                                         |  |
| 25b. REGISTRAR'S SIGNATURE John J. Connel                                                                                                                                                                                                                                                                   |  |                                                                             |  | 25c. REGISTRAR'S SIGNATURE                                                                                                                               |  |                                                                                                                         |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, copy be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                   |  | 8 3 2 7 7 4 3                                                                                                                                            |  |                                                                                                                         |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                   |  | REG. NO.                                                                                                                                                 |  |                                                                                                                         |                                              |
| 1. DECEASED NAME (TYPE OR PRINT) <b>DELMAR J. LAING</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>10 23 1983</b>                                                                                                       |  | 7b. HOUR <b>9:50 P.M.</b>                                                                                               |                                              |
| 3. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE <b>White</b>                                                                                                              |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Apr. 13 1922</b>                                                                                                      |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS                                                                           |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>District of Columbia</b>                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                        |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.                                                              |                                              |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Insurance Examiner</b>                                                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Geico Ins.</b>                                                                     |                                              |
| 13a. STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 13b. COUNTY <b>Montgomery</b>                                                                                                     |  | 13c. CITY OR TOWN <b>Silver Spring</b>                                                                                                                   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                              |
| 13e. STREET ADDRESS <b>501 Vierling Drive</b>                                                                                                                                                                                                                                                                                                                                                 |  | 13f. ZIP CODE <b>20904</b>                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter N. Laing</b>                                                                                                                                                                                                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Matilda C. Bailey</b>                                                               |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>                                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO. <b>WW11 577-14-9921</b>                                                                                  |  | 17. INFORMANT <b>Robert A. Laing-son - (same as 13e)</b>                                                                                                 |  |                                                                                                                         |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Bronchogenic Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Emphysema</b> |  |                                                                                                                                   |  |                                                                                                                                                          |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                           |  |                                                                                                                                   |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                             |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>                                                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                                                                           |  |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |                                              |
| 22a. I certify that (D) (this hospital) attended the deceased from <b>10</b> , 19 <b>82</b> , to <b>10</b> , 19 <b>83</b> , that (U) (we) lost saw the deceased alive on <b>10/20/83</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (U) (we) (did) (did not) view the body after death.                             |  |                                                                                                                                   |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 22b. SIGNATURE <b>Jay Weiner</b>                                                                                                                                                                                                                                                                                                                                                              |  | DEGREE                                                                                                                            |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <b>10/24/83</b>                                                                                        |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jay Weiner MD</b>                                                                                                                                                                                                                                                                                                                                    |  | 22e. ADDRESS <b>4701 Randolph Rd Rockville, Md</b>                                                                                |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPEC) <b>Cremation</b>                                                                                                                                                                                                                                                                                                                                       |  | 23b. DATE <b>10-27-1983</b>                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>                                                                                                |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>                                                         |                                              |
| 24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi Funeral Home</b>                                                                                                                                                                                                                                                                                                                                   |  | ADDRESS <b>11800 N.H. Ave., Silver Spring, Md.</b>                                                                                |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 25 1983</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Laing</b>                                                                         |                                              |

BP



Montgomery Silver Spring 20304  
Insurance Examiner Police Inv.  
Montgomery 2  
A.  
2  
Walter  
M.  
Living  
Married  
C.  
Nataly  
Yes  
Will  
577-16-9221 Robert A. Living-son - (same as 19a)

Examination 10-27-1968 Lee's Crematory  
11800 N.E. Ave.  
Hines Memorial Home Silver Spring, Md.  
Washington, D.C.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

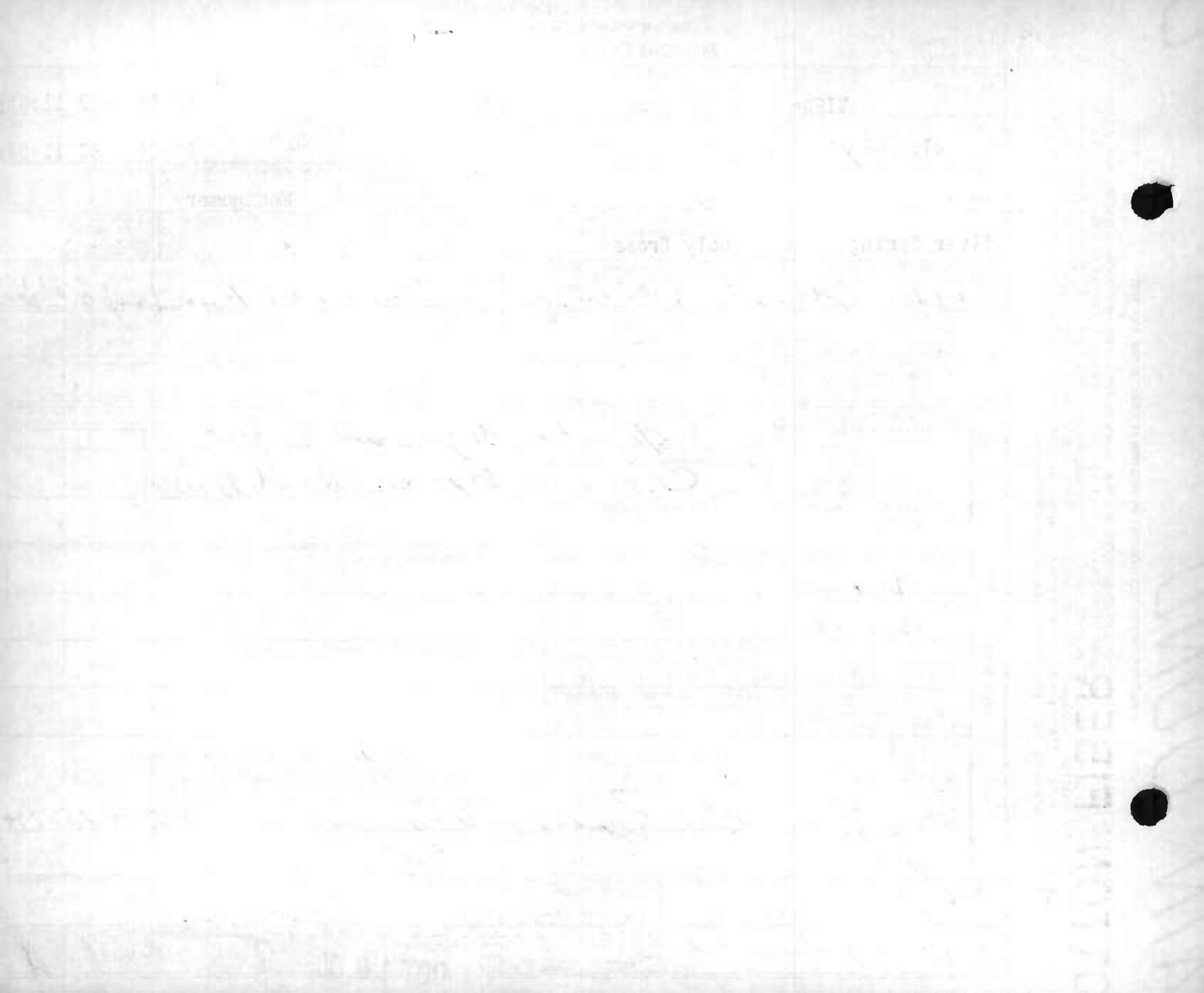
DMMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                     |          |                  |                                                             |                   |                     |                                                                                                                                                          |  |  |                                                                                                                                                                                                                           |  |  |                                                                                                                                    |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------|----------|------------------|-------------------------------------------------------------|-------------------|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                 |          |                  | 2a. DATE KNOWN OF DEATH                                     |                   |                     | 2b. DATE OF DEATH                                                                                                                                        |  |  | 2c. DATE OF DEATH                                                                                                                                                                                                         |  |  | 2d. DATE OF DEATH                                                                                                                  |  |  |
| VIEN= Quang LAM                                                                                                                     |          |                  | 10 14 1983                                                  |                   |                     | 10 14 1983                                                                                                                                               |  |  | 10 14 1983                                                                                                                                                                                                                |  |  | 11:51                                                                                                                              |  |  |
| 3. SEX                                                                                                                              | 4. RACE  | 5. DATE OF BIRTH | 6. AGE (IN YEARS)                                           | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                                     |  |  | 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                 |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                                                                           |  |  |
| male                                                                                                                                | Oriental | Sept. 15, 1909   | 74 YRS.                                                     |                   |                     | Montgomery                                                                                                                                               |  |  | Silver Spring                                                                                                                                                                                                             |  |  | Holy Cross                                                                                                                         |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                           |          |                  | 7b. CITIZEN OF WHAT COUNTRY?                                |                   |                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                                                                                                      |  |  | 10. CITY OR TOWN OF DEATH                                                                                                          |  |  |
| Viet Nam                                                                                                                            |          |                  | Permanent Residence                                         |                   |                     |                                                                                                                                                          |  |  | Montgomery                                                                                                                                                                                                                |  |  | Silver Spring                                                                                                                      |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                       |          |                  | 12b. KIND OF BUSINESS OR INDUSTRY                           |                   |                     | 13a. STATE                                                                                                                                               |  |  | 13b. COUNTY                                                                                                                                                                                                               |  |  | 13c. CITY OR TOWN                                                                                                                  |  |  |
| US Govt.                                                                                                                            |          |                  | Retired                                                     |                   |                     | MD                                                                                                                                                       |  |  | Mont.                                                                                                                                                                                                                     |  |  | S. 15th                                                                                                                            |  |  |
| 14. FATHER'S NAME                                                                                                                   |          |                  | 15. MOTHER'S MAIDEN NAME                                    |                   |                     | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                                                                                             |  |  | 16b. SOCIAL SECURITY NO.                                                                                                                                                                                                  |  |  | 17. INFORMANT                                                                                                                      |  |  |
| Van Quang Lam                                                                                                                       |          |                  | Muoi Thi Nguyen                                             |                   |                     | None                                                                                                                                                     |  |  | 216 94 2643                                                                                                                                                                                                               |  |  | 6201 North West Crain Hwy                                                                                                          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                           |          |                  | 19. DATE OF OPERATION                                       |                   |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                        |  |  | 20. AUTOPSY?                                                                                                                                                                                                              |  |  | 21a. EXTERNAL CAUSE WAS                                                                                                            |  |  |
| PART I DEATH WAS CAUSED BY:                                                                                                         |          |                  | None                                                        |                   |                     | None                                                                                                                                                     |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                       |  |  | UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                        |  |  |
| IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u>                                                                                    |          |                  |                                                             |                   |                     |                                                                                                                                                          |  |  |                                                                                                                                                                                                                           |  |  | 21b. TIME OF INJURY                                                                                                                |  |  |
| 4291                                                                                                                                |          |                  |                                                             |                   |                     |                                                                                                                                                          |  |  |                                                                                                                                                                                                                           |  |  | HOUR A.M. MONTH DAY YEAR                                                                                                           |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.                                       |          |                  |                                                             |                   |                     |                                                                                                                                                          |  |  |                                                                                                                                                                                                                           |  |  | P.M. 19                                                                                                                            |  |  |
| (b) <u>Chronic Myocardial Dis.</u>                                                                                                  |          |                  |                                                             |                   |                     |                                                                                                                                                          |  |  |                                                                                                                                                                                                                           |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                      |  |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                      |          |                  |                                                             |                   |                     |                                                                                                                                                          |  |  |                                                                                                                                                                                                                           |  |  |                                                                                                                                    |  |  |
| (c)                                                                                                                                 |          |                  |                                                             |                   |                     |                                                                                                                                                          |  |  |                                                                                                                                                                                                                           |  |  |                                                                                                                                    |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |          |                  |                                                             |                   |                     |                                                                                                                                                          |  |  |                                                                                                                                                                                                                           |  |  |                                                                                                                                    |  |  |
| 21d. INJURY OCCURRED                                                                                                                |          |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                   |                     | 21f. LOCATION                                                                                                                                            |  |  | 22a. I certify that I took charge of the remains described above, held on                                                                                                                                                 |  |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |          |                  |                                                             |                   |                     | STREET CITY OR TOWN COUNTY STATE                                                                                                                         |  |  | death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  | TITLE (SPECIFY)                                                                                                                    |  |  |
| ACTUAL SIGNATURE                                                                                                                    |          |                  | EXAMINER'S NAME (TYPE OR PRINT)                             |                   |                     | ADDRESS                                                                                                                                                  |  |  | DATE SIGNED                                                                                                                                                                                                               |  |  | 23a. BURNING, CREMATION, REMOVAL (SPECIFY)                                                                                         |  |  |
| John S. Rogers                                                                                                                      |          |                  | John S. Rogers                                              |                   |                     | 1919 Seminary Rd. S.S. Md.                                                                                                                               |  |  | OCT 15 1983                                                                                                                                                                                                               |  |  | 23b. DATE                                                                                                                          |  |  |
|                                                                                                                                     |          |                  |                                                             |                   |                     |                                                                                                                                                          |  |  |                                                                                                                                                                                                                           |  |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                 |  |  |
|                                                                                                                                     |          |                  |                                                             |                   |                     |                                                                                                                                                          |  |  |                                                                                                                                                                                                                           |  |  | Lee's Crematory                                                                                                                    |  |  |
|                                                                                                                                     |          |                  |                                                             |                   |                     |                                                                                                                                                          |  |  |                                                                                                                                                                                                                           |  |  | Washington, D.C.                                                                                                                   |  |  |
|                                                                                                                                     |          |                  |                                                             |                   |                     |                                                                                                                                                          |  |  |                                                                                                                                                                                                                           |  |  | 24. FUNERAL DIRECTOR                                                                                                               |  |  |
|                                                                                                                                     |          |                  |                                                             |                   |                     |                                                                                                                                                          |  |  |                                                                                                                                                                                                                           |  |  | Hines/Rinaldi Funeral Home                                                                                                         |  |  |
|                                                                                                                                     |          |                  |                                                             |                   |                     |                                                                                                                                                          |  |  |                                                                                                                                                                                                                           |  |  | 11800 New Hampshire Ave                                                                                                            |  |  |
|                                                                                                                                     |          |                  |                                                             |                   |                     |                                                                                                                                                          |  |  |                                                                                                                                                                                                                           |  |  | Silver Spring, Md.                                                                                                                 |  |  |
|                                                                                                                                     |          |                  |                                                             |                   |                     |                                                                                                                                                          |  |  |                                                                                                                                                                                                                           |  |  | OCT 18 1983                                                                                                                        |  |  |
|                                                                                                                                     |          |                  |                                                             |                   |                     |                                                                                                                                                          |  |  |                                                                                                                                                                                                                           |  |  | John J. Carver                                                                                                                     |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                 |                                                                                                                                                             |                                                                                  |                                                                                                                                            | REG. NO.                                                                                        |                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>FLORENCE E. LANHAM</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                 |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 15, 1983</b>                   |                                                                                                                                            | 2b. HOUR<br><b>3:55am</b>                                                                       |                                                                                                                            |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br><b>CAUC.</b>                                                                                                                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APRIL 17, 1898</b>                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.                                |                                                                                                                                            | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                       |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>                                                                                                                                                                                                                                                                                                                                                                                                                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                    |                                                                                                                                            |                                                                                                 |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NURSE</b> |                                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |                                                                                                                            |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                 |                                                                                                                                                             | 13b. COUNTY<br><b>MONT.</b>                                                      | 13c. CITY OR TOWN<br><b>STL. SPG.</b>                                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HUMPHERY M. LANHAM</b>                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                 |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ETHEL CARLYE</b>             |                                                                                                                                            |                                                                                                 |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                 | 16b. SOCIAL SECURITY NO.<br><b>577-07-1816</b>                                                                                                              |                                                                                  | 17. INFORMANT<br><b>Niece</b> ADDRESS<br><b>200 BADEN ST. STL. SPG. MD. 20901</b>                                                          |                                                                                                 |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>REDUCED PULMONARY APPETITE.</b><br><b>0389</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF <b>SEPSIS</b><br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7-11</b><br><b>48 hrs -</b> |                                                                                                                                                 |                                                                                                                                                             |                                                                                  |                                                                                                                                            |                                                                                                 |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                 |                                                                                                                                                             |                                                                                  |                                                                                                                                            |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                              |                                                                                                 |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                                                 |                                                                                                                            |
| 22a. I certify that if (this hospital) attended the deceased from _____ 1983, to _____ 1983, that I (we) last saw the deceased alive on _____ 1983 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death.)                                                                                                                                                                                   |                                                                                                                                                 |                                                                                                                                                             |                                                                                  |                                                                                                                                            |                                                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br><b>Donald E. Lewis</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                 | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                                  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br><b>10/15/83</b>                                                                                        |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DONALD E. LEWIS</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                 | 22e. ADDRESS<br><b>OLNEY, MD.</b>                                                                                                                           |                                                                                  |                                                                                                                                            |                                                                                                 |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                 | 23b. DATE<br><b>OCT. 18, 1983</b>                                                                                                                           |                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HILLSBORO CEMETERY</b>                                                                            |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>HILLSBORO LOUDOUN VA.</b>                                                 |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                 | 500 UNIV. BLVD. W.<br><b>STL. SPG. MD. 20901</b>                                                                                                            |                                                                                  | 15a. DATE REC'D. BY REGISTRAR<br><b>OCT 20 1983</b>                                                                                        |                                                                                                 |                                                                                                                            |

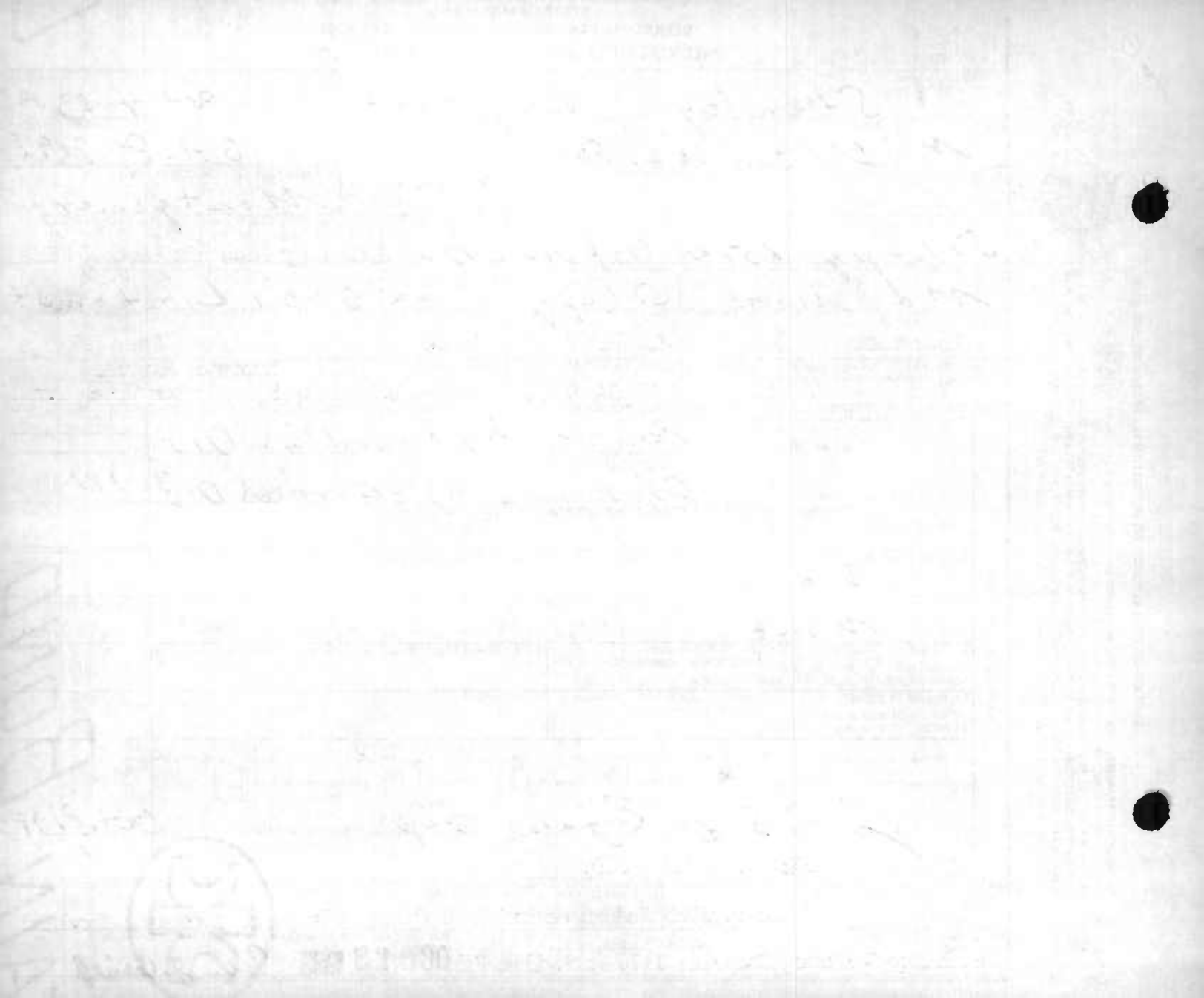
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                    |  |                     |  |                                                                                                                                   |  |                                                                                              |  |                                                                                                                                                          |                                    | REG. NO.                                                                      |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-------------------------------------------------------------------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                     |  |                                                                                                                                   |  |                                                                                              |  |                                                                                                                                                          |                                    | 2a. DATE KNOWN OF DEATH                                                       |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Stanley Lapkoff</b>                                                                                                                                                                                                                                                                                                                                                               |  |                     |  |                                                                                                                                   |  |                                                                                              |  |                                                                                                                                                          |                                    | 2b. DATE KNOWN OF DEATH<br><b>Oct 7 1983</b>                                  |  |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br><b>W</b> |  | 5. DATE OF BIRTH (MONTH DAY YEAR)<br><b>July 10 27 56</b>                                                                         |  | 6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. MONTHS DAYS<br><b>27</b>                              |  | 7c. DATE PRONOUNCED DEAD<br><b>Oct. 8 1983</b>                                                                                                           |                                    | 2d. HOUR<br><b>A</b>                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, DC</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                        |  |                                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b>                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1574 Oakview Dr</b> |  |                                                                                              |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Auto Body Mechanic</b>                                                               |                                    | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Auto Bodies</b>                       |  |
| 13a. USUAL RESIDENCE (IF NOT IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY COUNTY<br><b>MD North Silver Spg</b>                                                                                                                                                                                                                                                                                                |  |                     |  | 13b. CITY OR TOWN<br><b>Silver Spg</b>                                                                                            |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d. STREET ADDRESS<br><b>9021 Linton St</b>                                                                                                             |                                    |                                                                               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Alexander Lapkoff</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                     |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Rose Janofsky</b>                                                                |  |                                                                                              |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WW II</b>                                       |                                    |                                                                               |  |
| 16b. SOCIAL SECURITY NO.<br><b>577-34-0676</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                     |  | 17. INFORMANT<br><b>Potomac, Maryland Charles Schwartz; 8516 Hunter Creek Trail</b>                                               |  |                                                                                              |  |                                                                                                                                                          |                                    |                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis</b><br><b>4291</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) <b>Chronic Myocardial Dis</b><br>(c) <b>None</b>                                                                                                        |  |                     |  |                                                                                                                                   |  |                                                                                              |  |                                                                                                                                                          |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>hrs</b>                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>None</b>                                                                                                                                                                                                                                                                                             |  |                     |  |                                                                                                                                   |  |                                                                                              |  |                                                                                                                                                          |                                    |                                                                               |  |
| 19a. DATE OF OPERATION<br><b>None</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  |                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                 |  |                                                                                              |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                      |                                    |                                                                               |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                        |  |                     |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                    |  |                                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                            |                                    |                                                                               |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                     |  |                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                       |  |                                                                                              |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                    |                                                                               |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                     |  |                                                                                                                                   |  |                                                                                              |  |                                                                                                                                                          |                                    |                                                                               |  |
| ACTUAL SIGNATURE<br><b>John S. Rogers</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  |                     |  |                                                                                                                                   |  | TITLE (SPECIFY)<br><b>Dep</b>                                                                |  |                                                                                                                                                          | DATE SIGNED<br><b>Oct. 11 1983</b> |                                                                               |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>JOHN S. ROGERS, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                     |  |                                                                                                                                   |  | ADDRESS                                                                                      |  |                                                                                                                                                          |                                    |                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                     |  | 23b. DATE<br><b>Oct 10, 1983</b>                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Judean Memorial Gardens</b>                         |  |                                                                                                                                                          |                                    | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Olney; Montgomery, Maryland</b> |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>                                                                                                                                                                                                                                                                                                                                                        |  |                     |  |                                                                                                                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 13 1983</b>                                          |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Givish</b>                                                                                                      |                                    |                                                                               |  |

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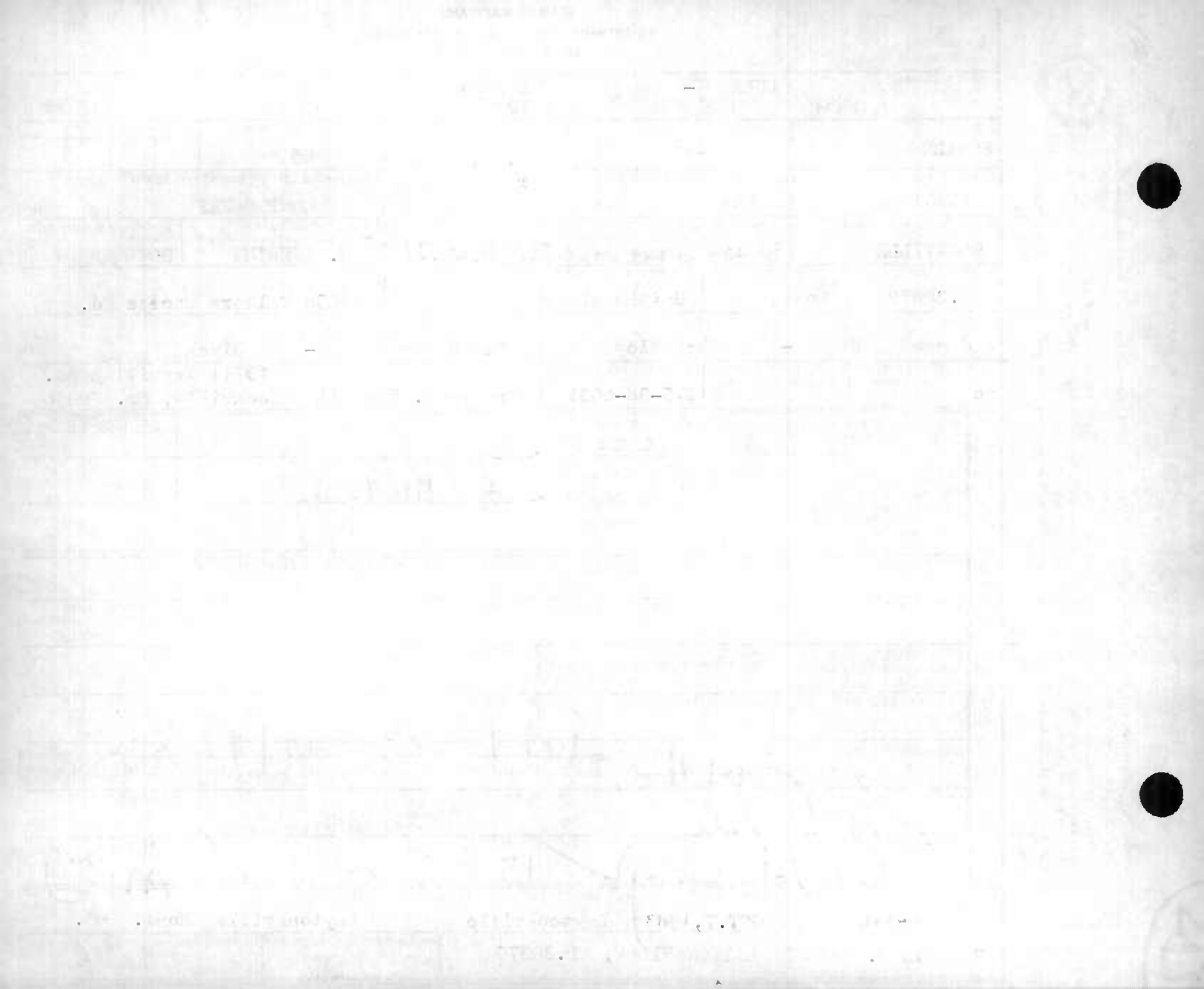


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                            |  |  |                                                                                                                                                    |  |                                                                       |                                                                                                                                                             |                                                                                                 |                                                                                                 |                                                               |                                                                                                                            |                                                        |                                                            |                                |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|------------------------------------------------------------|--------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                    |  |  |                                                                                                                                                    |  | REG. NO.                                                              |                                                                                                                                                             |                                                                                                 |                                                                                                 |                                                               |                                                                                                                            |                                                        |                                                            |                                |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lula</b>                                                                                                                                                                                                                                                                                                                                 |  |  |                                                                                                                                                    |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10/4/83</b>                 |                                                                                                                                                             |                                                                                                 |                                                                                                 |                                                               | 2b. HOUR<br><b>1300 M</b>                                                                                                  |                                                        |                                                            |                                |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                         |  |  | 4. RACE<br><b>WHITE</b>                                                                                                                            |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>SEPT. 6, 1918</b>            |                                                                                                                                                             |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.                                               |                                                               |                                                                                                                            | IF UNDER 1 YEAR<br>MONTHS DAYS                         |                                                            | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>                                                                                                                                                                                                                                                                                                                    |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                         |  |                                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD. |                                                                                                                            |                                                        |                                                            |                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>ROCKVILLE</b>                                                                                                                                                                                                                                                                                                                                   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Shady Grove Adventist Hospital</b> |  |                                                                       |                                                                                                                                                             |                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>H. KEEPING</b>           |                                                               |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>GOVERNMENT</b> |                                                            |                                |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MR. 20879</b>                                                                                                                                                                                                                                                  |  |  | 13b. COUNTY<br><b>Mont,</b>                                                                                                                        |  | 13c. CITY OR TOWN<br><b>Gaithersburg</b>                              |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 | 13e. STREET ADDRESS<br><b>18630 Walkers Choice Rd.</b>        |                                                                                                                            |                                                        |                                                            |                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James - Christley</b>                                                                                                                                                                                                                                                                                                              |  |  |                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Susan - Black</b> |                                                                                                                                                             |                                                                                                 |                                                                                                 |                                                               |                                                                                                                            |                                                        |                                                            |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>                                                                                                                                                                                                                                                                                                  |  |  |                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br><b>215-38-6631</b>                        |                                                                                                                                                             | 17. INFORMANT<br><b>Barbara L. Fossett</b>                                                      |                                                                                                 |                                                               |                                                                                                                            |                                                        | ADDRESS<br><b>19711 Travillah Rd. Rockville, Md. 20850</b> |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>C2CHC212</b><br><b>1629</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>C2CINOMA of the lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |                                                                                                                                                    |  |                                                                       |                                                                                                                                                             |                                                                                                 |                                                                                                 |                                                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |                                                        |                                                            |                                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>                                                                                                                                                                                                                                       |  |  |                                                                                                                                                    |  |                                                                       |                                                                                                                                                             |                                                                                                 |                                                                                                 |                                                               |                                                                                                                            |                                                        |                                                            |                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                          |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                   |  |                                                                       |                                                                                                                                                             |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                        |                                                            |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                        |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                  |  |                                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                                                 |                                                                                                 |                                                               |                                                                                                                            |                                                        |                                                            |                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                             |  |                                                                       | 21f. LOCATION<br>STREET<br><b>15 E Deer Pk Dr</b>                                                                                                           |                                                                                                 | CITY OR TOWN<br><b>Gaithersburg</b>                                                             |                                                               | COUNTY<br><b>MD</b>                                                                                                        |                                                        | STATE                                                      |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/4/83</b> to <b>10/4/83</b> that (I) (we) last saw the deceased alive on <b>10/4/83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                        |  |  |                                                                                                                                                    |  |                                                                       |                                                                                                                                                             |                                                                                                 |                                                                                                 |                                                               |                                                                                                                            |                                                        |                                                            |                                |  |
| 22b. SIGNATURE<br><b>S. Delansk</b>                                                                                                                                                                                                                                                                                                                                             |  |  |                                                                                                                                                    |  | DEGREE<br><b>MD</b>                                                   |                                                                                                                                                             |                                                                                                 |                                                                                                 |                                                               | 22c. DATE SIGNED                                                                                                           |                                                        |                                                            |                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                           |  |  |                                                                                                                                                    |  | 22e. ADDRESS<br><b>15 E Deer Pk Dr Gaithersburg MD</b>                |                                                                                                                                                             |                                                                                                 |                                                                                                 |                                                               |                                                                                                                            |                                                        |                                                            |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                      |  |  | 23b. DATE<br><b>OCT. 7, 1983</b>                                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Laytonsville</b>             |                                                                                                                                                             |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN<br><b>Laytonsville</b> COUNTY<br><b>Mont.</b> STATE<br><b>Md.</b> |                                                               |                                                                                                                            |                                                        |                                                            |                                |  |
| 24. FUNERAL DIRECTOR<br><b>FRANCIS H. B ARBER LAYTONSVILLE, MD. 20879</b>                                                                                                                                                                                                                                                                                                       |  |  |                                                                                                                                                    |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 7 1983</b>                    |                                                                                                                                                             |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                             |                                                               |                                                                                                                            |                                                        |                                                            |                                |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |                                                                        |                                                        |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                            |                                                                                                                            |                                                                    |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--|
| 1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                           |  | REG. NO.                                                                                                                               |                                                                        |                                                        |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                            |                                                                                                                            |                                                                    |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Edwin J. Larson</i>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        |                                                                        |                                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR <i>Oct. 22, 1983</i>                                                                                                    |                                                                                                 |                                                                                      | 2b. HOUR<br>MIN. <i>1215</i>                                               |                                                                                                                            |                                                                    |  |
| 3. SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><i>Caucasian</i>                                                                                                            |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR <i>May 30, 1909</i> |                                                                                                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>74</i> YRS.                                               |                                                                                      |                                                                            | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |                                                                    |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><i>Minnesota</i>                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                          |                                                                        |                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.              |                                                                                                                            |                                                                    |  |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Holy Cross Hospital</i> |                                                                        |                                                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Type Operator</i>                                                                    |                                                                                                 |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>G.P.O.</i>                         |                                                                                                                            |                                                                    |  |
| 13a. STATE<br><i>MARYLAND</i>                                                                                                                                                                                                                                                                                                                                                |  | 13b. COUNTY<br><i>Montgomery</i>                                                                                                       |                                                                        | 13c. CITY OR TOWN<br><i>Silver Spring</i>              |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                      |                                                                            | 13e. STREET ADDRESS<br><i>1616 Flora Lane 20910</i>                                                                        |                                                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Mons Larson</i>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                        |                                                                        |                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Paulina B. Illian</i>                                                                                   |                                                                                                 |                                                                                      |                                                                            |                                                                                                                            |                                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>Yes</i>                                                                                                                                                                                                                                                                                              |  |                                                                                                                                        |                                                                        |                                                        | 16b. SOCIAL SECURITY NO.<br><i>469-03-9758</i>                                                                                                              |                                                                                                 | 17. INFORMANT<br><i>Bertha M. Larson Wife</i>                                        |                                                                            |                                                                                                                            |                                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Brain negative Sepsis</i><br><i>1893</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Never taken Urteral Cancer</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>2 mo</i> |  |                                                                                                                                        |                                                                        |                                                        |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                            |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>microscopic</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>a</i>                                                                                                                                                                                                                                    |  |                                                                                                                                        |                                                                        |                                                        |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                            |                                                                                                                            |                                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                        |                                                                                                                                                             |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                     |  |                                                                                                                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                        |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                      |                                                                            |                                                                                                                            |                                                                    |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                    |  |                                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                        |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                      |                                                                            |                                                                                                                            |                                                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10-20</i> , 19 <i>83</i> , to <i>10-22</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>10-22</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.        |  |                                                                                                                                        |                                                                        |                                                        |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                            |                                                                                                                            |                                                                    |  |
| 22b. SIGNATURE<br><i>Frederick G. Barr</i>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        |                                                                        |                                                        |                                                                                                                                                             | DEGREE<br><i>M.D.</i>                                                                           |                                                                                      |                                                                            | 22c. DATE SIGNED                                                                                                           |                                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>FREDERICK G. BARR</i>                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |                                                                        |                                                        |                                                                                                                                                             | 22e. ADDRESS<br><i>106 IRVING ST. N.W. WASH. D.C.</i>                                           |                                                                                      |                                                                            |                                                                                                                            |                                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        | 23b. DATE<br><i>Oct. 26, 1983</i>                                      |                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Ft. Snelling National</i>                                                                                          |                                                                                                 |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>St. Paul Ramsey Minn.</i> |                                                                                                                            |                                                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>Francis J. Collins</i><br>ADDRESS <i>500 University Boulevard, W. Silver Spring, Md.</i>                                                                                                                                                                                                                                                     |  |                                                                                                                                        |                                                                        |                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 27 1983</i>                                             |                                                                                      |                                                                            | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Smith</i>                                                                         |                                                                    |  |

BP \_\_\_\_\_



Know all men by these presents, that [illegible] of the County of [illegible] State of Texas, for and in consideration of the sum of [illegible] Dollars, to [illegible] in hand paid by [illegible], the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said [illegible] of the County of [illegible] State of Texas, all that certain [illegible]

tract of land, situate in the County of [illegible] State of Texas, containing [illegible] acres, more or less, as the same may appear by the plat of [illegible] in and to the records of the County of [illegible] State of Texas, to have and to hold unto the said [illegible] and his heirs and assigns forever.

And the said [illegible] do hereby certify that the within and foregoing premises are not subject to any lien or claim of any person, and that the same are free and clear of all taxes, assessments, liens and claims of every kind and description.

And the said [illegible] do hereby certify that the within and foregoing premises are not subject to any lien or claim of any person, and that the same are free and clear of all taxes, assessments, liens and claims of every kind and description.

And the said [illegible] do hereby certify that the within and foregoing premises are not subject to any lien or claim of any person, and that the same are free and clear of all taxes, assessments, liens and claims of every kind and description.

And the said [illegible] do hereby certify that the within and foregoing premises are not subject to any lien or claim of any person, and that the same are free and clear of all taxes, assessments, liens and claims of every kind and description.

And the said [illegible] do hereby certify that the within and foregoing premises are not subject to any lien or claim of any person, and that the same are free and clear of all taxes, assessments, liens and claims of every kind and description.

And the said [illegible] do hereby certify that the within and foregoing premises are not subject to any lien or claim of any person, and that the same are free and clear of all taxes, assessments, liens and claims of every kind and description.

And the said [illegible] do hereby certify that the within and foregoing premises are not subject to any lien or claim of any person, and that the same are free and clear of all taxes, assessments, liens and claims of every kind and description.

And the said [illegible] do hereby certify that the within and foregoing premises are not subject to any lien or claim of any person, and that the same are free and clear of all taxes, assessments, liens and claims of every kind and description.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                             |  |                                                                                                                                                             |                                                                                                 |                                                                |                                                                                                                            |  |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                             |  |                                                                                                                                                             | REG. NO.                                                                                        |                                                                |                                                                                                                            |  |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Paul S. Lauder                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                             |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 8 83                                                     |                                                                |                                                                                                                            |  |                                              |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                             |  |                                                                                                                                                             | 2b. HOUR<br>1635 M                                                                              |                                                                |                                                                                                                            |  |                                              |
| 4. RACE<br>White                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 31 1899                                                                                          |  |                                                                                                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.                                                      |                                                                | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                             |  | IF UNDER 24 HRS<br>HOURS MIN.                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Texas                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                      |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD          |                                                                                                                            |  |                                              |
| 10. CITY OR TOWN OF DEATH<br>Rockville                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Shady Grove Adventist Hospital |  |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Electrician                 |                                                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>Pepco                                                                                 |  |                                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                             |  |                                                                                                                                                             | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                |                                                                                                                            |  |                                              |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY<br>Montgomery                                                                                                                   |  | 13c. CITY OR TOWN<br>Boys,                                                                                                                                  |                                                                                                 | 13d. STREET ADDRESS<br>12608-W Old Baltimore Rd.               |                                                                                                                            |  |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Calvin Lauder                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                             |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Effie - Unknown                                |                                                                |                                                                                                                            |  |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-                                                                                |  | 17. INFORMANT<br>Mary E. Lauder                                                                                                                             |                                                                                                 | ADDRESS:<br>12608 W. Baltimore Rd.<br>Boys, Md. 20811          |                                                                                                                            |  |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>3109 IMMEDIATE CAUSE (a) Aspiration Pneumonia / Sepsis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Organic Brain Syndrome<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.<br>pericardial effusion, right-sided Vascular Disease, Aortic Aneurysm |  |                                                                                                                                             |  |                                                                                                                                                             |                                                                                                 |                                                                |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                            |  |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                                                 |                                                                |                                                                                                                            |  |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                 |                                                                |                                                                                                                            |  |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 04 9 19 83 to 04 8 19 83, that (I) (we) post saw the deceased alive on 04 9 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                             |  |                                                                                                                                             |  |                                                                                                                                                             |                                                                                                 |                                                                |                                                                                                                            |  |                                              |
| 22b. SIGNATURE<br>Douglas R. Shumaker, MD                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                             |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                                                                                 | 22c. DATE SIGNED<br>10/9/83                                    |                                                                                                                            |  |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DOUGLAS R. SHUMAKER, MD                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                             |  | 22e. ADDRESS<br>615 W. MONTGOMERY AVE, ROCKVILLE, MD 20850                                                                                                  |                                                                                                 |                                                                |                                                                                                                            |  |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br>10/9/83                                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lee's Crematory                                                                                                       |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Washington, D.C. |                                                                                                                            |  |                                              |
| 24. FUNERAL DIRECTOR<br>Gartner Sandison F.H. Gaithersburg, Md. 20878                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 13 1983                                                                                                                |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel                   |                                                                                                                            |  |                                              |



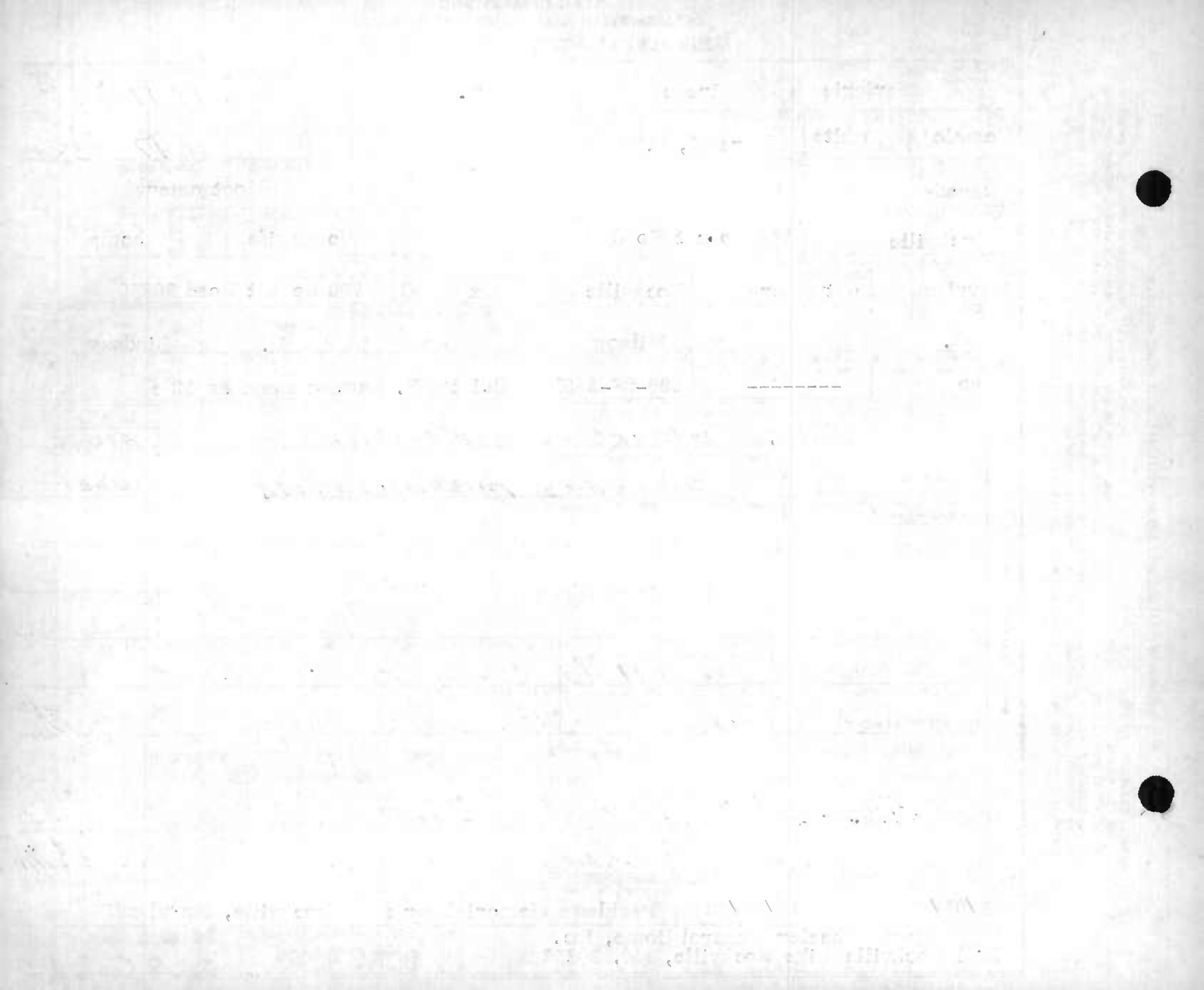
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                      |  |                                                                                                                                                                        |  |                                                                                                               |  |                                                                                                                                                                            |  |                                                                                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Marjorie</b>                                                                                                                                                                                                                                                                                                                                                                                            |  | FIRST<br><b>Irene</b>                                                                                                                |  | MIDDLE<br><b>Lawson</b>                                                                                                                                                |  | LAST                                                                                                          |  | 20. DATE KNOWN OF DEATH<br>MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/><br><b>10 17 1983</b> |  | 21. HOUR                                                                            |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><b>white</b>                                                                                                              |  | 5. DATE OF BIRTH<br>MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/><br><b>March 7, 1920</b> |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>63</b>                                                               |  | 7. IF UNDER 1 YR.<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>                                                                                         |  | 7. IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN <input type="checkbox"/>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Canada</b>                                                                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>            |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b>                                                     |  |                                                                                                                                                                            |  |                                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>                                                                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>700 Robert Road</b> |  |                                                                                                                                                                        |  |                                                                                                               |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                                                                          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>home</b>                                    |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY<br><b>Montgomery</b>                                                                                                     |  | 13c. CITY OR TOWN<br><b>Rockville</b>                                                                                                                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |  | 13e. STREET ADDRESS<br><b>700 Robert Road 20850</b>                                                                                                                        |  |                                                                                     |  |
| 14. FATHER'S NAME<br>FIRST <b>C.</b> MIDDLE <b>Milsom</b> LAST <b>Milsom</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                      |  |                                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Edna</b> MIDDLE <b>B.</b> LAST <b>Lindsay</b>                            |  |                                                                                                                                                                            |  |                                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br><b>220-28-5631</b>                                                                                                                         |  | 17. INFORMANT<br>ADDRESS<br><b>Quinton Y. Lawson same as 13 e</b>                                             |  |                                                                                                                                                                            |  |                                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) <b>CORONARY ARTERIOSCLEROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                   |  |                                                                                                                                      |  |                                                                                                                                                                        |  |                                                                                                               |  |                                                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>ACUTE</b><br><b>INDIST</b>       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                      |  |                                                                                                                                                                        |  |                                                                                                               |  |                                                                                                                                                                            |  |                                                                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>DIABETES MELLITUS</b>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                      |  |                                                                                                                                                                        |  |                                                                                                               |  |                                                                                                                                                                            |  |                                                                                     |  |
| 19a. DATE OF OPERATION<br><b>—</b>                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>—</b>                                                                                                          |  |                                                                                                               |  |                                                                                                                                                                            |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>10 17 1983</b>                                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>COLLAPSED AT HOME</b>     |  |                                                                                                                                                                            |  |                                                                                     |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home</b>                                                                                             |  | 21f. LOCATION<br>STREET <b>700 ROBERT RD</b> CITY OR TOWN <b>ROCKVILLE</b> COUNTY <b>MONT</b> STATE <b>MD</b> |  |                                                                                                                                                                            |  |                                                                                     |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |                                                                                                                                      |  |                                                                                                                                                                        |  |                                                                                                               |  |                                                                                                                                                                            |  |                                                                                     |  |
| ACTUAL SIGNATURE<br><b>Francis C Mayle</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                      |  | TITLE (SPECIFY)<br>M.D. <b>DEPT</b> MEDICAL EXAMINER                                                                                                                   |  |                                                                                                               |  | DATE SIGNED<br><b>10/17/83</b>                                                                                                                                             |  |                                                                                     |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Francis C Mayle</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                      |  | ADDRESS<br><b>8200 W. CONNERS AVE BETHESDA MD</b>                                                                                                                      |  |                                                                                                               |  |                                                                                                                                                                            |  |                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br><b>10/22/83</b>                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Memorial Park</b>                                                                                                    |  |                                                                                                               |  | 23d. LOCATION<br>CITY OR TOWN <b>Rockville, Maryland</b> COUNTY STATE                                                                                                      |  |                                                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Tyson Wheeler Funeral Home, Inc.</b> ADDRESS <b>1331 Rockville Pike Rockville, Md. 20852</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                      |  |                                                                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 24 1983</b>                                                           |  | 25b. REGISTRAR'S SIGNATURE<br><b>John E. ...</b>                                                                                                                           |  |                                                                                     |  |

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IT MUST BE FILED WITH THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 4 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

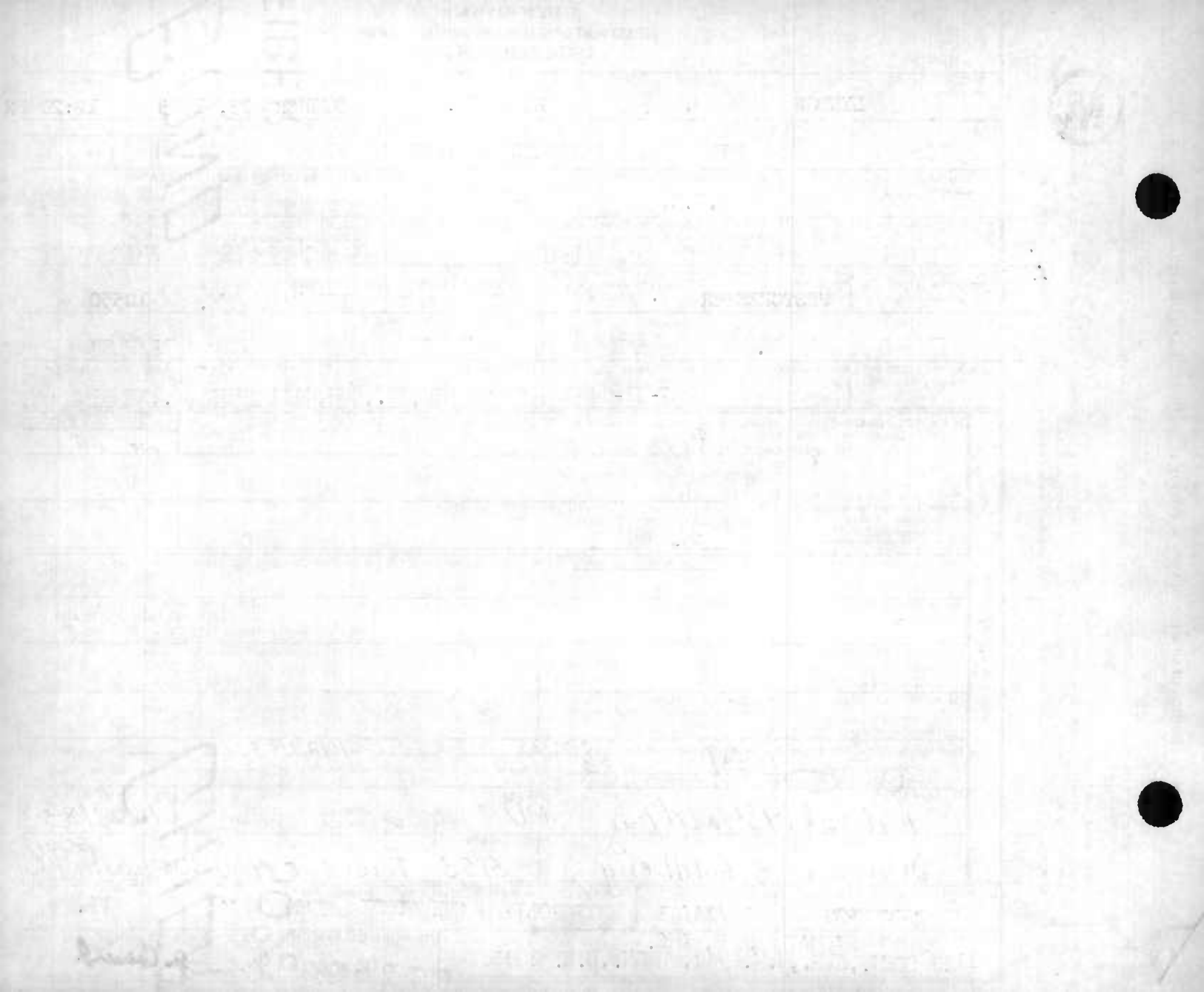
BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                            |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                               | 2b. HOUR                                                                       |                                   |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                  |                                                                                                        | MONTH DAY YEAR                                                                                                                                           |                                                               | MONTHS DAYS HOURS MIN.                                                         |                                   |
| LYNDON E. LEE SR.                                                                                                                                                                                                                                                                                                                 |                                                                                                        | OCTOBER 23, 1983                                                                                                                                         |                                                               | 12:20 PM                                                                       |                                   |
| 3. SEX                                                                                                                                                                                                                                                                                                                            | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)                               | 7. IF UNDER 1 YEAR                                                             |                                   |
| MALE                                                                                                                                                                                                                                                                                                                              | WHITE                                                                                                  | OCTOBER 30, 1887                                                                                                                                         | 95                                                            | MONTHS DAYS HOURS MIN.                                                         |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                         | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |                                                                                |                                   |
| NEW YORK                                                                                                                                                                                                                                                                                                                          | U.S.A.                                                                                                 |                                                                                                                                                          | MONTGOMERY MD.                                                |                                                                                |                                   |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY |
| WHEATON                                                                                                                                                                                                                                                                                                                           | MANOR CARE WHEATON                                                                                     |                                                                                                                                                          | SELF EMPLOYED                                                 |                                                                                | CHIROPRACTOR                      |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                      |                                                                                                        | 13b. CITY OR TOWN                                                                                                                                        | 13c. STREET ADDRESS / ZIP CODE                                | 13d. INSIDE CITY LIMITS?                                                       |                                   |
| NEW YORK                                                                                                                                                                                                                                                                                                                          |                                                                                                        | WESTCHESTER                                                                                                                                              | 170 PARK AVE.                                                 | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                   |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                 |                                                                                                        | 15. MOTHER'S MAIDEN NAME                                                                                                                                 |                                                               | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)              |                                   |
| EDMUND W. LEE                                                                                                                                                                                                                                                                                                                     |                                                                                                        | CARRIE REIFLER                                                                                                                                           |                                                               | NO                                                                             |                                   |
| 16b. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                          |                                                                                                        | 17. INFORMANT                                                                                                                                            |                                                               | ADDRESS                                                                        |                                   |
| 067-32-9483                                                                                                                                                                                                                                                                                                                       |                                                                                                        | LYNDON LEE, JR., SON                                                                                                                                     |                                                               | MARYLAND 20895                                                                 |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                                                                                                                                                                                                                          |                                                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                             |                                                               | 24 HR.                                                                         |                                   |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| IMMEDIATE CAUSE (a) Pneumonia                                                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| DUE TO, OR AS A CONSEQUENCE OF (b) debility                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| DUE TO, OR AS A CONSEQUENCE OF (c) old age                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                            |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                               | 20a. AUTOPSY?                                                                  |                                   |
|                                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                               | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                |                                                                                                        | 21b. TIME OF INJURY                                                                                                                                      |                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |
|                                                                                                                                                                                                                                                                                                                                   |                                                                                                        | HOUR A.M. MONTH DAY YEAR                                                                                                                                 |                                                               |                                                                                |                                   |
|                                                                                                                                                                                                                                                                                                                                   |                                                                                                        | P.M. 19                                                                                                                                                  |                                                               |                                                                                |                                   |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                              |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                               | 21f. LOCATION                                                                  |                                   |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                          |                                                               | STREET CITY OR TOWN COUNTY STATE                                               |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/21/83, 19____, to 10/23/83, 19____, that (I) (we) last saw the deceased alive on 10/23/83, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                    |                                                                                                        | DEGREE                                                                                                                                                   |                                                               | 22c. DATE SIGNED                                                               |                                   |
| Deborah B Goldberg                                                                                                                                                                                                                                                                                                                |                                                                                                        | MD                                                                                                                                                       |                                                               | 10/23/83                                                                       |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                             |                                                                                                        | 22e. ADDRESS                                                                                                                                             |                                                               | 22f. DATE REC'D. BY REGISTRAR                                                  |                                   |
| Deborah B Goldberg                                                                                                                                                                                                                                                                                                                |                                                                                                        | 5153 Tilden St NW Washington DC 20016                                                                                                                    |                                                               | 22g. REGISTRAR'S SIGNATURE                                                     |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                         |                                                                                                        | 23b. DATE                                                                                                                                                |                                                               | 23c. NAME OF CEMETERY OR CREMATORY                                             |                                   |
| CREMATION                                                                                                                                                                                                                                                                                                                         |                                                                                                        | 10/24/83                                                                                                                                                 |                                                               | METROPOLITAN CREMATORY                                                         |                                   |
| 23d. LOCATION                                                                                                                                                                                                                                                                                                                     |                                                                                                        | 23e. NAME OF FUNERAL DIRECTOR                                                                                                                            |                                                               | 23f. DATE REC'D. BY REGISTRAR                                                  |                                   |
| ALEXANDRIA COUNTY VA.                                                                                                                                                                                                                                                                                                             |                                                                                                        | RICHARD RAPP, INC.                                                                                                                                       |                                                               | 23g. REGISTRAR'S SIGNATURE                                                     |                                   |
| 1120 CONN., AVE., N.W. #940, WASH., D.C. 20036                                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                          |                                                               | 23h. DATE REC'D. BY REGISTRAR                                                  |                                   |
|                                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                               | 23i. REGISTRAR'S SIGNATURE                                                     |                                   |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|                                                                                   |                                                                                                                                           |                                                                                                                                                             |                                                                                                 |                                                               |                                                                 |
|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-----------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNA C. LEHMAN</b>                         |                                                                                                                                           |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCT 23, 1983</b>                                      |                                                               | 2b. HOUR<br><b>3:00</b> M                                       |
| 3. SEX<br><b>Female</b>                                                           | 4. RACE<br><b>Caucasian</b>                                                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Mar. 12 1910</b>                                                                                                   |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.             | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>               | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD. |                                                                 |
| 10. CITY OR TOWN OF DEATH<br><b>Wheaton</b>                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2108 Henderson Avenue</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Library Assistant</b>    |                                                               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>County Montgomery</b>   |
| 13a. STATE<br><b>Maryland</b>                                                     | 13b. COUNTY<br><b>Montgomery</b>                                                                                                          | 13c. CITY OR TOWN<br><b>Wheaton</b>                                                                                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>2108 Henderson Avenue 20902</b>     |                                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Daniel G. Stuftt</b>                 |                                                                                                                                           | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carrie E. Bowman</b>                                                                                    |                                                                                                 | 16. ADDRESS<br><b>16100 A.E. Mullinix Woodbine, Md. 21797</b> |                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |                                                                                                                                           | 16b. SOCIAL SECURITY NO.<br><b>722-12-1499</b>                                                                                                              |                                                                                                 | 17. INFORMANT<br><b>Son Daniel R. Lehman</b>                  |                                                                 |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **METASTATIC BREAST CARCINOMA**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**1 YEAR**

1749  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

|                                                                                                                                                                                                                                                                                                                                               |                                                                        |                                                                                                                                            |                                                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                             |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 17, 1983</b> , to <b>OCT 23, 1983</b> , that (I) (we) last<br>saw the deceased alive on <b>OCT 17, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |                                                                        |                                                                                                                                            |                                                                                                                               |
| 22b. SIGNATURE<br><b>Eugene P. Flannery, MD</b>                                                                                                                                                                                                                                                                                               | DEGREE<br><b>MD</b>                                                    | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>24 OCT 83</b>                                                                                          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EUGENE P. FLANNERY</b>                                                                                                                                                                                                                                                                            |                                                                        | 22e. ADDRESS<br><b>18111 PRINCE PHILIP DR. OLNEY, MARYLAND 20832</b>                                                                       |                                                                                                                               |

|                                                               |                                   |                                                                   |                                                                             |
|---------------------------------------------------------------|-----------------------------------|-------------------------------------------------------------------|-----------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> | 23b. DATE<br><b>Oct. 26, 1983</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood Pr. Geo. Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Francis J. Collins</b>     |                                   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 27 1983</b>               | 25b. REGISTRAR'S SIGNATURE<br><b>Joan J. Connel</b>                         |
| 500 University Blvd., W. Silver Spring, Md.                   |                                   |                                                                   |                                                                             |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. Name of the plant or animal  
2. Locality  
3. Date  
4. Collector  
5. Number of specimens  
6. Description of the specimen  
7. Remarks

1. Name of the plant or animal  
2. Locality  
3. Date  
4. Collector  
5. Number of specimens  
6. Description of the specimen  
7. Remarks

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6. Description of the specimen  
7. Remarks

1. Name of the plant or animal  
2. Locality  
3. Date  
4. Collector  
5. Number of specimens  
6. Description of the specimen  
7. Remarks

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                    |  |                                                                                                                                                 |                                                                |                                                                                                                                                             |  |                                                                                                      |  |
|------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>James Earl Lehman Sr.</b>                |  |                                                                                                                                                 | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 23, 1983</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>10A.</b>                                                                              |  |
| 3. SEX<br><b>Male.</b>                                                             |  | 4. RACE<br><b>White.</b>                                                                                                                        |                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 1, 1908</b>                                                                                                   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b>                                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Howard Co. Laurel</b>              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                                 |                                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b>                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |                                                                |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Montg. Co. Trans.</b> |  |
| 13a. STATE<br><b>Maryland.</b>                                                     |  | 13b. COUNTY<br><b>Montg.</b>                                                                                                                    |                                                                | 13c. CITY OR TOWN<br><b>Silver Spring</b>                                                                                                                   |  | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jacob Dewey Lehman.</b>               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Florence Duvall.</b>                                                                        |                                                                |                                                                                                                                                             |  |                                                                                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b> |  | 16b. SOCIAL SECURITY NO.<br><b>212-14-5610</b>                                                                                                  |                                                                | 17. INFORMANT<br>ADDRESS<br><b>Florence Barrett Lehman. Wife. 13e</b>                                                                                       |  |                                                                                                      |  |

|                                                                                                                                                                                                                                         |  |                                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLUS</b>                                                                               |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>12 HRS.</b> |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>PANCREATIC CARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PROSTATIC CARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF |  | <b>6 MONTHS</b>                                                   |
|                                                                                                                                                                                                                                         |  | <b>4 YEARS</b>                                                    |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|                                                                                                                                                                                             |  |                                                                        |  |                                                                                      |  |                                                                                                                                       |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |  |                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |                                                                                                                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT. 1983</b> to <b>OCT 23, 1983</b> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                      |  |                                                                                                                                       |  |
| 22b. SIGNATURE<br><b>Eugene P. Flannery</b>                                                                                                                                                 |  |                                                                        |  | DEGREE<br><b>MD</b>                                                                  |  | 22c. DATE SIGNED<br><b>24 OCT 83</b>                                                                                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Eugene P. Flannery</b>                                                                                                                      |  |                                                                        |  | 22e. ADDRESS<br><b>18111 Prince Philip Dr. Olney, Md.</b>                            |  |                                                                                                                                       |  |

|                                                                   |  |                                   |  |                                                                                     |  |                                                                    |  |
|-------------------------------------------------------------------|--|-----------------------------------|--|-------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation.</b> |  | 23b. DATE<br><b>Oct. 25, 1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Crematory, Bladensburg Rd/</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>P. G. Co. Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Takoma Funeral Home.</b>       |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 27 1983</b>                                 |  |                                                                    |  |
|                                                                   |  |                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                    |  |                                                                    |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                                                                            |                                                          |                                                          |                                                                |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                           |                                                                                                        | 2a. DATE OF DEATH                                                   |                                                                                                                                                          | MONTH                                                                                                                                      | DAY                                                      | YEAR                                                     | 2b. HOUR                                                       |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                 |                                                                                                        | FIRST                                                               | MIDDLE                                                                                                                                                   | LAST                                                                                                                                       |                                                          |                                                          |                                                                |  |
| Etta                                                                                                                                                                                                                                                                                             |                                                                                                        | C.                                                                  | Leith                                                                                                                                                    | 10 1 83                                                                                                                                    |                                                          |                                                          | 5 <sup>30</sup> A M                                            |  |
| 3. SEX                                                                                                                                                                                                                                                                                           | 4. RACE                                                                                                |                                                                     | 5. DATE OF BIRTH                                                                                                                                         |                                                                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)                          |                                                          |                                                                |  |
| FEMALE                                                                                                                                                                                                                                                                                           | WHITE                                                                                                  |                                                                     | 5 4 1905                                                                                                                                                 |                                                                                                                                            | 78                                                       |                                                          |                                                                |  |
| 7a. BIRTHPLACE (COUNTRY)                                                                                                                                                                                                                                                                         | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |                                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH                     |                                                          |                                                                |  |
| VIRGINIA                                                                                                                                                                                                                                                                                         | U.S.A                                                                                                  |                                                                     |                                                                                                                                                          |                                                                                                                                            | Montgomery MD                                            |                                                          |                                                                |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                     | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |                                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                        |                                                          |                                                                |  |
| Bethesda                                                                                                                                                                                                                                                                                         | Suburban Hospital                                                                                      |                                                                     | HOUSEWIFE                                                                                                                                                |                                                                                                                                            |                                                          |                                                          |                                                                |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                          |                                                                                                        | 13a. STATE                                                          |                                                                                                                                                          | 13b. COUNTY                                                                                                                                | 13c. CITY OR TOWN                                        |                                                          |                                                                |  |
|                                                                                                                                                                                                                                                                                                  |                                                                                                        | Md.                                                                 |                                                                                                                                                          | Montg                                                                                                                                      | Dickersw                                                 |                                                          |                                                                |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                |                                                                                                        | 15. MOTHER'S MAIDEN NAME                                            |                                                                                                                                                          |                                                                                                                                            |                                                          |                                                          |                                                                |  |
| JAMES                                                                                                                                                                                                                                                                                            |                                                                                                        | GRIMES                                                              |                                                                                                                                                          | UNKNOWN                                                                                                                                    |                                                          |                                                          |                                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                |                                                                                                        | 16b. SOCIAL SECURITY NO.                                            |                                                                                                                                                          | 17. INFORMANT ADDRESS                                                                                                                      |                                                          |                                                          |                                                                |  |
|                                                                                                                                                                                                                                                                                                  |                                                                                                        | 214-169456                                                          |                                                                                                                                                          | Mrs. Cochran Gaithersburg Md.                                                                                                              |                                                          |                                                          |                                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                        |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                                                                            |                                                          |                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                                                                            |                                                          |                                                          |                                                                |  |
| IMMEDIATE CAUSE (a) acute myocardial infarction                                                                                                                                                                                                                                                  |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                                                                            |                                                          |                                                          |                                                                |  |
| 4100 DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                              |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                                                                            |                                                          |                                                          |                                                                |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                   |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                                                                            |                                                          |                                                          |                                                                |  |
| (b) ASHD                                                                                                                                                                                                                                                                                         |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                                                                            |                                                          |                                                          | yes                                                            |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                                                                            |                                                          |                                                          |                                                                |  |
| (c)                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                                                                            |                                                          |                                                          |                                                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.                                                                                                                                                              |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                                                                            |                                                          |                                                          |                                                                |  |
| CVA, Scurvy, Period furber                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                                                                            |                                                          |                                                          |                                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                           |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                          |                                                                                                                                            | 20a. AUTOPSY?                                            |                                                          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|                                                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                                                                            | YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                          | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                               |                                                                                                        | 21b. TIME OF INJURY                                                 |                                                                                                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                              |                                                          |                                                          |                                                                |  |
|                                                                                                                                                                                                                                                                                                  |                                                                                                        | HOUR A.M. MONTH DAY YEAR                                            |                                                                                                                                                          |                                                                                                                                            |                                                          |                                                          |                                                                |  |
|                                                                                                                                                                                                                                                                                                  |                                                                                                        | P.M. 19                                                             |                                                                                                                                                          |                                                                                                                                            |                                                          |                                                          |                                                                |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                             |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                          | 21f. LOCATION                                                                                                                              |                                                          |                                                          |                                                                |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                              |                                                                                                        |                                                                     |                                                                                                                                                          | CITY OR TOWN COUNTY STATE                                                                                                                  |                                                          |                                                          |                                                                |  |
|                                                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                     |                                                                                                                                                          | 2015 10-1 83                                                                                                                               |                                                          |                                                          |                                                                |  |
| 22a. I certify that (the deceased) attended the deceased from 7-30 19 83, to 10-1 19 83, that (we) last saw the deceased alive on 9-30 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (we) (did not) view the body after death. |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                                                                            |                                                          |                                                          |                                                                |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                   |                                                                                                        | DEGREE                                                              |                                                                                                                                                          | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                          | 22c. DATE SIGNED                                         |                                                                |  |
| John S. S. AIA                                                                                                                                                                                                                                                                                   |                                                                                                        | MD                                                                  |                                                                                                                                                          |                                                                                                                                            |                                                          | 10-1-83                                                  |                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                            |                                                                                                        | 22e. ADDRESS                                                        |                                                                                                                                                          |                                                                                                                                            |                                                          |                                                          |                                                                |  |
| John S. S. AIA                                                                                                                                                                                                                                                                                   |                                                                                                        | 809 Viers mill Rd                                                   |                                                                                                                                                          | Rd                                                                                                                                         |                                                          |                                                          |                                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                        |                                                                                                        | 23b. DATE                                                           |                                                                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                         |                                                          | 23d. LOCATION                                            |                                                                |  |
| Burial                                                                                                                                                                                                                                                                                           |                                                                                                        | 10/4/83                                                             |                                                                                                                                                          | Monacy Center                                                                                                                              |                                                          | Beallsville Md.                                          |                                                                |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                             |                                                                                                        | NAME                                                                |                                                                                                                                                          | ADDRESS                                                                                                                                    |                                                          | 75a. DATE REC'D. BY REGISTRAR 75b. REGISTRAR'S SIGNATURE |                                                                |  |
| W. C. Helt                                                                                                                                                                                                                                                                                       |                                                                                                        | Baltimore Md.                                                       |                                                                                                                                                          | 108001                                                                                                                                     |                                                          | 7-1983 John J. Connel                                    |                                                                |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

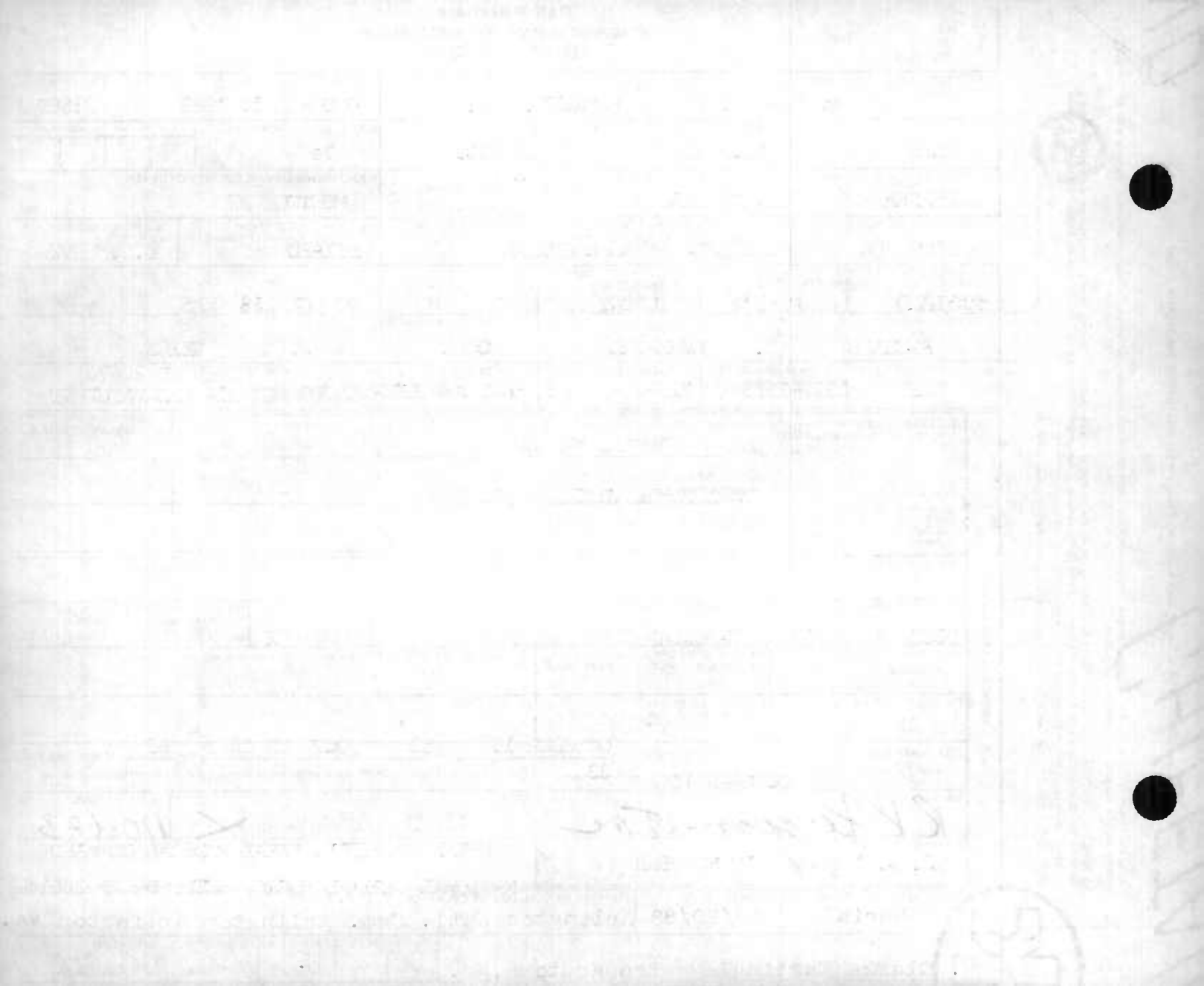
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                   |  | REG. NO.                                                                                                                                                    |  |                                                                                                                         |                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                   |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                            |  |                                                                                                                         |                                              |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>TAYLOR NMN LEMKUHL, Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                   |  | OCTOBER 16 1983                                                                                                                                             |  |                                                                                                                         |                                              |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br>CAUCASIAN                                                                                                              |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>MAY 11 1909                                                                                                              |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>74                                                                              |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEBRASKA                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>UNITED STATES                                                                                     |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                                                                  |                                              |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BETHESDA NAVAL HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED                                                                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. NAVY                                                                          |                                              |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 13b. COUNTY<br>ST MARY'S                                                                                                          |  | 13c. CITY OR TOWN<br>PATUXENT RIVER                                                                                                                         |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                              |
| 13e. STREET ADDRESS<br>PO BOX 214 NAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 13f. ZIP CODE<br>20670                                                                                                            |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br>RICHARD H. LEHMKUHL                                                                                                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>CORA H. GLICK                                                             |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br>1929-1955                                                                                             |  | 17. INFORMANT ADDRESS<br>MARY ANN LEMKUHL PO BOX 214 NAS PATUXENT RIVER MD 20670                                                                            |  |                                                                                                                         |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>4439<br>DUE TO, OR AS A CONSEQUENCE OF<br><b>PERIPHERAL VASCULAR DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION<br>OCTOBER 13 1983                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>VASCULAR INSUFFICIENCY                                                        |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>P.M. 19                                                                                                                                                                                                                                                                                                                                                             |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                         |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 10</u> , 19 <u>83</u> , to <u>OCTOBER 16</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>OCTOBER 16</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.                                                                                                                                                                                          |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                         |                                              |
| 22b. SIGNATURE<br>R. K. Ferguson LT MC USNR                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>17 Oct 83                                                                                           |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. K. FERGUSON LT MC USNR                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                   |  | 22e. ADDRESS<br>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND<br>NATIONAL CAPITAL REGION BETHESDA MD 20814                                                          |  |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br>10/20/83                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington Natl. Cem. Arlington Va.                                                                                    |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                 |                                              |
| 24. FUNERAL DIRECTOR NAME<br>W. Clarke Mattingley Leonardtown, Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 20 1983                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel                                                                            |                                              |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                         |                                                                            |                                                                                                                                                             |                                                                             |                                                                                                                                            |                                                                                      |                                                                                                                            |                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Bernard J Lenet</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 - 7 - 83</b>                  |                                                                                                                                                             |                                                                             | 2b. HOUR<br><b>3:06 PM</b>                                                                                                                 |                                                                                      |                                                                                                                            |                                              |  |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>W</b>                                                                                                                     |                                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 10 14</b>                                                                                                        |                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.                                                                                          |                                                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                              |                                                                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                                                              |                                                                                      |                                                                                                                            |                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSPITAL</b> |                                                                            |                                                                                                                                                             |                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESMAN</b>                                                        |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>APPLIANCE</b>                                                                      |                                              |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                         | 13b. COUNTY<br><b>MONTGOMERY</b>                                           |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>WHEATON</b>                                         |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br><b>3608 JANET RD.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>EDWARD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ROSE ROBINSON</b>      |                                                                                                                                                             |                                                                             |                                                                                                                                            |                                                                                      |                                                                                                                            |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br><b>228-07-7913</b>                             |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>ROSE H. LENET SAME AS 13e</b>                |                                                                                                                                            |                                                                                      |                                                                                                                            |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4149</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>CORONARY DISEASE</b><br>(c) <b>GENERALIZED ATHEROSCLEROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10+ yrs</b> |  |                                                                                                                                         |                                                                            |                                                                                                                                                             |                                                                             |                                                                                                                                            |                                                                                      |                                                                                                                            |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>EMPHYSEMA - GANGRENE OF LEFT FOOT - CHRONIC RENAL FAILURE</b>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                         |                                                                            |                                                                                                                                                             |                                                                             |                                                                                                                                            |                                                                                      |                                                                                                                            |                                              |  |
| 19a. DATE OF OPERATION<br><b>9-13-83</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>GANGRENE @ FOOT</b> |                                                                                                                                                             |                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                                                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                 |                                                                                                                                                             |                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                             |                                                                                      |                                                                                                                            |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)     |                                                                                                                                                             |                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                                      |                                                                                                                            |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>AUG 30 1983</b> to <b>OCT 7th 1983</b> , that (I) (we) lost<br>saw the deceased alive on <b>OCT-7th 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                                                                                       |  |                                                                                                                                         |                                                                            |                                                                                                                                                             |                                                                             |                                                                                                                                            |                                                                                      |                                                                                                                            |                                              |  |
| 22b. SIGNATURE<br><b>D. A. Mathews, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                         | DEGREE<br><b>MD</b>                                                        |                                                                                                                                                             |                                                                             | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                      | 22c. DATE SIGNED<br><b>10/8/83</b>                                                                                         |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAFAEL A. MATHEWS</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                         | 22e. ADDRESS<br><b>13018 GEORGIA AVE, S.S. MD 20906</b>                    |                                                                                                                                                             |                                                                             |                                                                                                                                            |                                                                                      |                                                                                                                            |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                         | 23b. DATE<br><b>OCT 10, 1983</b>                                           |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>KING DAVID MEM. CEM FAIRFAX VA</b> |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                           |                                                                                                                            |                                              |  |
| 24. FUNERAL DIRECTOR<br><b>FRANCIS J COLLINS 580 UNIV. BLVD. W., S.S., MD</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                         | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 13 1983</b>                        |                                                                                                                                                             | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Smith</b>                          |                                                                                                                                            |                                                                                      |                                                                                                                            |                                              |  |

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LARGE

OCT 10 1982 KING DAVID MEN. COM. LIBRARY

FRANCIS L COLLINS 500 BLVD. BLVD. W. 2.2.04

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                |                                |                                                                |                                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------|----------------------------------------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           | 2a. DATE OF DEATH                                                                                                                                           |                                                                  | MONTH                                                                          | DAY                            | YEAR                                                           | 2b. HOUR                                                       |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           | FIRST                                                                                                                                                       | MIDDLE                                                           | LAST                                                                           |                                |                                                                |                                                                |
| NORMAN                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           | W.                                                                                                                                                          | LEVINE                                                           |                                                                                | 10-18-83                       |                                                                | 7:53a.m.                                                       |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                       | 4. RACE                                                                                                   | 5. DATE OF BIRTH                                                                                                                                            |                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                |                                | IF UNDER 1 YEAR                                                |                                                                |
| Male                                                                                                                                                                                                                                                                                                                                                                                                         | White                                                                                                     | MONTH DAY YEAR<br>4-28-20                                                                                                                                   |                                                                  | 63 YRS.                                                                        |                                | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.                     |                                                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                    | 7b. CITIZEN OF WHAT COUNTRY?                                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                           |                                |                                                                |                                                                |
| New York                                                                                                                                                                                                                                                                                                                                                                                                     | USA                                                                                                       |                                                                                                                                                             |                                                                  | Montgomery, MD.                                                                |                                |                                                                |                                                                |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                | 12b. KIND OF BUSINESS INDUSTRY |                                                                |                                                                |
| Silver Spring                                                                                                                                                                                                                                                                                                                                                                                                | Holy Cross Hospital                                                                                       |                                                                                                                                                             | Entrepreneur                                                     |                                                                                | SHOP<br>Retail Gift /          |                                                                |                                                                |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                 |                                                                                                           | 13b. CITY OR TOWN                                                                                                                                           |                                                                  | 13c. INSIDE CITY LIMITS?                                                       |                                | 13d. STREET ADDRESS                                            |                                                                |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                           | 13b. COUNTY                                                                                                                                                 |                                                                  | 13c. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |                                | 13d. 814 Loxford Terrace - 20901                               |                                                                |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           | Montgomery                                                                                                                                                  |                                                                  | Silver Spring                                                                  |                                |                                                                |                                                                |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           | 15. MOTHER'S MAIDEN NAME                                                                                                                                    |                                                                  |                                                                                |                                |                                                                |                                                                |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           | FIRST MIDDLE LAST                                                                                                                                           |                                                                  |                                                                                |                                |                                                                |                                                                |
| Benjamin                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           | Levine                                                                                                                                                      |                                                                  | Blanche Handler                                                                |                                |                                                                |                                                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                         |                                                                                                           | 16b. SOCIAL SECURITY NO.                                                                                                                                    |                                                                  | 17. INFORMANT ADDRESS                                                          |                                |                                                                |                                                                |
| Yes                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           | WWII                                                                                                                                                        |                                                                  | Beatrice M. Levine; 814 Loxford Terrace; Silver Spring, Md. 20901              |                                |                                                                |                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           | 121-07-9694                                                                                                                                                 |                                                                  |                                                                                |                                |                                                                |                                                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>perforated viscera (small bowel)</u><br><u>2028</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>irritation</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Lymphoma</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                |                                |                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>24 hrs.</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><u>Bacterial Meningitis</u>                                                                                                                                                                                                                                          |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                |                                |                                                                |                                                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                  | 20a. AUTOPSY?                                                                  |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           |                                                                                                                                                             |                                                                  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                     |                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                |                                                                |                                                                |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                               |                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                |                                                                |                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                |                                |                                                                |                                                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 18</u> , 19 <u>83</u> , to <u>Oct 18</u> , 19 <u>83</u> , that (I) (we) lost<br>saw the deceased alive on <u>Oct 18</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                               |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                |                                |                                                                |                                                                |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           | DEGREE                                                                                                                                                      |                                                                  | 22c. DATE SIGNED                                                               |                                |                                                                |                                                                |
| <u>WY Marcus</u>                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           |                                                                                                                                                             |                                                                  | 10/18/83                                                                       |                                |                                                                |                                                                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                           | 22e. ADDRESS                                                                                                                                                |                                                                  |                                                                                |                                |                                                                |                                                                |
| William Y. Marcus, MD                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                           | 10301 Georgia Ave., #205; Silver Spring, Md.                                                                                                                |                                                                  |                                                                                |                                |                                                                |                                                                |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           | 23b. DATE                                                                                                                                                   |                                                                  | 23c. NAME OF CEMETERY OR CREMATORY                                             |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |                                                                |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           | 10/20/83                                                                                                                                                    |                                                                  | Judean Memorial Gdns.                                                          |                                | Olney; Montgomery; Maryland                                    |                                                                |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                           | 25a. DATE REC'D. BY REGISTRAR                                                                                                                               |                                                                  | 25b. REGISTRAR'S SIGNATURE                                                     |                                |                                                                |                                                                |
| DANZANSKY-GOLDBERG MEMORIAL CHAPELS                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           | OCT 20 1983                                                                                                                                                 |                                                                  | <u>John J. Connel</u>                                                          |                                |                                                                |                                                                |
| 1170 Rockville Pike; Rockville, Maryland 20852                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                |                                |                                                                |                                                                |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and returned to the registrar, it should be completely filled in by the funeral director. Then date and sign the certificate. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene for burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO THE SECRETARY OF AGRICULTURE  
WASHINGTON, D.C.

FROM THE  
[illegible]

[illegible text]

[illegible text]



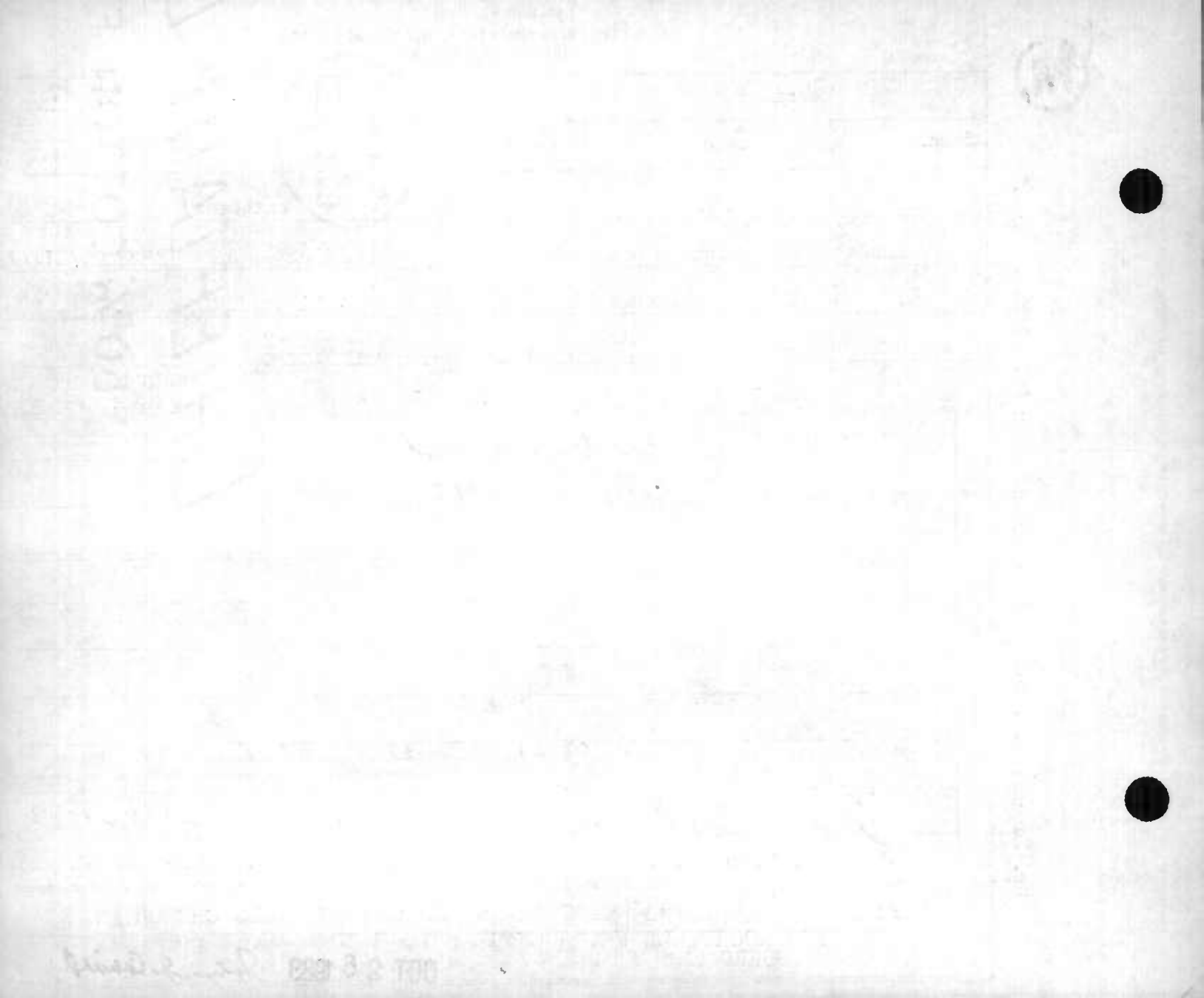
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once. Dr. Rogers, M.D. released certificate for Dr. Scott to sign.

## MEDICAL CERTIFICATION

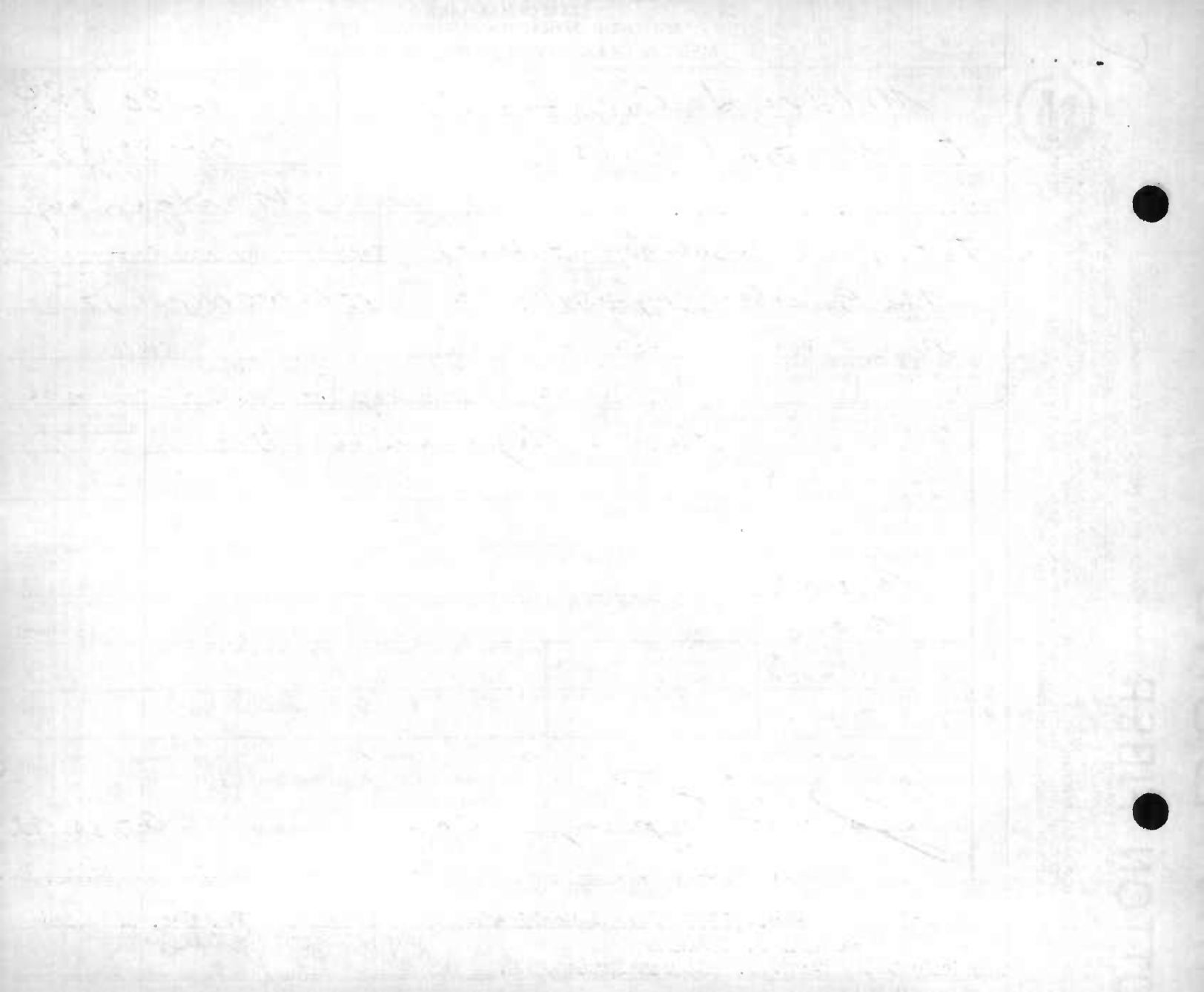
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                |  |                                                                                                                                                             | REG. NO. |                                                                                                                            |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|----------------------------------------------------------------------------------------------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                |  | FIRST MIDDLE LAST<br>Bessie Levinson                                                                                           |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 21 83                                                                                                             |          | 2b. HOUR<br>8:15p <sup>M</sup>                                                                                             |  |  |
| 3. SEX<br>female                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br>cauc                                                                                                                |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>DEC. 24 1889                                                                                                          |          | 6. AGE (IN YEARS LAST BIRTHDAY)<br>93<br>YRS                                                                               |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>LITHUANIA                                                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                                                                     |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda                                                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SALESWOMAN                                                                              |          | 12b. KIND OF BUSINESS OR INDUSTRY<br>RETAIL/CLOTH                                                                          |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD.                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY<br>MONTG.                                                                                                          |  | 13c. CITY OR TOWN<br>ROCKVILLE                                                                                                                              |          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>SAMUEL ---- LEVINSON                                                                                                                                                                                                                                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN-----                                                                  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO NONE                                                 |          | 16b. SOCIAL SECURITY NO.<br>577-10-7982                                                                                    |  |  |
| 17. INFORMANT<br>ADDRESS<br>MRS. ROSE BROTMAN                                                                                                                                                                                                                                                                                                                                                                                      |  | 259 CONGRESSIONAL<br>ROCKVILLE, MD. LA.                                                                                        |  |                                                                                                                                                             |          |                                                                                                                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br><u>4140</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>C.H.F. - ASHD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                |  |                                                                                                                                                             |          |                                                                                                                            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                |  |                                                                                                                                                             |          |                                                                                                                            |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                               |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |          |                                                                                                                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |          |                                                                                                                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 21</u> , 19 <u>83</u> , to <u>Oct 21</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Oct 21</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                          |  |                                                                                                                                |  |                                                                                                                                                             |          |                                                                                                                            |  |  |
| 22b. SIGNATURE<br><u>John E. Scott, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                       |  | DEGREE                                                                                                                         |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |          | 22c. DATE SIGNED<br>10/21/83                                                                                               |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John E. Scott, M.D.                                                                                                                                                                                                                                                                                                                                                                       |  | 22e. ADDRESS<br>8600 Old Georgetown Rd., Bethesda, Md. 20814                                                                   |  |                                                                                                                                                             |          |                                                                                                                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br>10-23-83                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br>KING DAVID MEM GDN                                                                                                    |          | 23d. LOCATION<br>CITY OR TOWN STATE<br>FALLS CHURCH, VA.                                                                   |  |  |
| 24. FUNERAL DIRECTOR<br>DANZANSKY-GOLDBERG MEM CHP. INC.                                                                                                                                                                                                                                                                                                                                                                           |  | 1170 ROCKVILLE PK. ROCKVILLE MD                                                                                                |  | DATE REC'D. BY REGISTRAR                                                                                                                                    |          | REGISTRAR'S SIGNATURE<br>OCT 26 1983 <u>John J. Carver</u>                                                                 |  |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                |  |                                    |  |                                                                                                                                 |  |                                                                                              |  |                                                                                                                                                          |  |                                                                          |  | REG. NO.                                                                         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <u>Mildred Cecelia Lewis</u>                                                                                                                                                                                                                                                                                                                                                                          |  |                                    |  |                                                                                                                                 |  |                                                                                              |  |                                                                                                                                                          |  |                                                                          |  | 2a. DATE KNOWN OF DEATH <u>Oct 30, 1983</u>                                      |  |
| 3. SEX <u>F</u>                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE <u>W</u>                   |  | 5. DATE OF BIRTH <u>Jan 7, 1903</u>                                                                                             |  | 6. AGE (IN YEARS) <u>80</u> YRS.                                                             |  | IF UNDER 1 YR. MONTHS DAYS                                                                                                                               |  | IF UNDER 24 HRS. HOURS MIN.                                              |  | 2c. DATE PRONOUNCED DEAD <u>Oct 30, 1983</u>                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Washington, D. C.</u>                                                                                                                                                                                                                                                                                                                                                                     |  |                                    |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                                                                      |  |                                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Mt. Vernon City, Md.</u>         |  |                                                                                  |  |
| 10. CITY OR TOWN OF DEATH <u>Tak Park</u>                                                                                                                                                                                                                                                                                                                                                                                              |  |                                    |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Wash Advent Hosp</u> |  |                                                                                              |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Telephone Operator Commerce Dept</u>                                                    |  |                                                                          |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                |  |
| 13a. STATE <u>Md</u>                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY <u>Prince George's</u> |  | 13c. CITY OR TOWN <u>Hyattsville</u>                                                                                            |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <u>1506 McVinnick St</u>                                                                                                             |  | 20783                                                                    |  |                                                                                  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>William Roy McIntire</u>                                                                                                                                                                                                                                                                                                                                                                        |  |                                    |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Bessie Goode</u>                                                                  |  |                                                                                              |  |                                                                                                                                                          |  |                                                                          |  |                                                                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>No</u>                                                                                                                                                                                                                                                                                                                                                           |  |                                    |  | 16b. SOCIAL SECURITY NO. <u>579-24-2069</u>                                                                                     |  |                                                                                              |  | 17. INFORMANT <u>Jean Frances Fox</u> ADDRESS <u>Same as 13</u>                                                                                          |  |                                                                          |  |                                                                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><u>4291</u> IMMEDIATE CAUSE (a) <u>Sudden Myocardial Inf.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                |  |                                    |  |                                                                                                                                 |  |                                                                                              |  |                                                                                                                                                          |  |                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><u>None</u>                                                                                                                                                                                                                                                                                     |  |                                    |  |                                                                                                                                 |  |                                                                                              |  |                                                                                                                                                          |  |                                                                          |  |                                                                                  |  |
| 19a. DATE OF OPERATION <u>None</u>                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                               |  |                                                                                              |  |                                                                                                                                                          |  |                                                                          |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    |  |                                    |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>                                                                     |  |                                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |  |                                                                          |  |                                                                                  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                               |  |                                    |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                     |  |                                                                                              |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                          |  |                                                                                  |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                    |  |                                                                                                                                 |  |                                                                                              |  |                                                                                                                                                          |  |                                                                          |  |                                                                                  |  |
| ACTUAL SIGNATURE <u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                    |  | TITLE (SPECIFY) <u>M.D.</u>                                                                                                     |  |                                                                                              |  | MEDICAL EXAMINER <u>[Signature]</u>                                                                                                                      |  |                                                                          |  | DATE SIGNED <u>Oct 30, 1983</u>                                                  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <u>John S. Rogers, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                            |  |                                    |  | ADDRESS <u>1919 Seminary Road Silver Spring, Md.</u>                                                                            |  |                                                                                              |  |                                                                                                                                                          |  |                                                                          |  |                                                                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                |  |                                    |  | 23b. DATE <u>Nov. 2, 1983</u>                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>                                  |  |                                                                                                                                                          |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Adelphi Pr. Geo. Maryland</u> |  |                                                                                  |  |
| 24. FUNERAL DIRECTOR NAME <u>Francis J. Collins</u>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                    |  | 25a. DATE REC'D. BY REGISTRAR <u>NOV 2 1983</u>                                                                                 |  |                                                                                              |  | 25b. REGISTRAR SIGNATURE <u>[Signature]</u>                                                                                                              |  |                                                                          |  |                                                                                  |  |
| 500 University Blvd., W. Silver Spring, Md.                                                                                                                                                                                                                                                                                                                                                                                            |  |                                    |  |                                                                                                                                 |  |                                                                                              |  |                                                                                                                                                          |  |                                                                          |  |                                                                                  |  |



Classed by Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

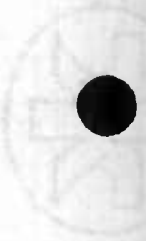
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>NORTON<br/>NORTON</b>                                                                                                                                                                                                                                                                                                                                                                  |  | MIDDLE<br><b>LIGHTENSTEIN<br/>LICHTENSTEIN</b>                                                                                                  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>OCT. 7 1983</b>                                                                                                      |  | 2b. HOUR<br><b>7 A M</b>                                                                                                   |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>White</b>                                                                                                                         |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>March 2, 1926</b>                                                                                                     |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b>                                                                               |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>                                                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales Representative</b>                                                             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Belluzzi Co.</b>                                                                   |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 13b. COUNTY<br><b>Montgomery</b>                                                                                                                |  | 13c. CITY OR TOWN<br><b>Silver Spring</b>                                                                                                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Aaron</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Helen</b>                                                                                      |  | 13e. STREET ADDRESS<br><b>14500 MacBeth Drive</b>                                                                                                           |  | 13f. ADDRESS<br><b>20906</b>                                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>4100</b>                                                                         |  | 17. INFORMANT<br><b>Irving M. Lichtenstein</b>                                                                                                              |  | 17b. ADDRESS<br><b>10713 Weymouth Street<br/>Garrett Park, Md.</b>                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>HOURS</b> |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)<br><b>FALL</b>                                                               |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                          |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>1106 SPRING ST. SILVER SPRING MD</b>                                                                |  | 21g. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Adelphi, P. G., Md.</b>                                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>FALL</b> 19 <b>75</b> to <b>OCT. 7</b> 19 <b>83</b> , that (I) (we) lost <b>ALLIE</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                              |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Albert H. Grollman</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                 |  | DEGREE<br><b>MD</b>                                                                                                                                         |  | 22c. DATE SIGNED<br><b>10/9/83</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALBERT H. GROLLMAN</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                 |  | 22e. ADDRESS<br><b>1106 SPRING ST. SILVER SPRING MD</b>                                                                                                     |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br><b>10/11/1983</b>                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Lebanon Cemetery</b>                                                                                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Adelphi, P. G., Md.</b>                                                   |  |
| 24. FUNERAL DIRECTOR<br><b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1983</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>Barry J. Gough</b>                                                                        |  |
| 23e. ADDRESS<br><b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                                            |  |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE REGISTRAR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1 AND 2 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED AS A PERMIT FOR REMOVAL OF THE REMAINS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

21-61

|                                                                           |  |  |  |                                                               |  |  |  |                                                                               |  |  |  |                                      |  |  |  |                              |  |  |  |
|---------------------------------------------------------------------------|--|--|--|---------------------------------------------------------------|--|--|--|-------------------------------------------------------------------------------|--|--|--|--------------------------------------|--|--|--|------------------------------|--|--|--|
| 1- FOR STATE REGISTRAR                                                    |  |  |  | 2a. DATE KNOWN OF DEATH                                       |  |  |  | 2b. DATE OF ESTI- MATED                                                       |  |  |  | 2c. DATE PRONOUNCED DEAD             |  |  |  | 2d. DATE OF DEATH            |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                          |  |  |  | 2. DATE KNOWN OF DEATH                                        |  |  |  | 2b. DATE OF ESTI- MATED                                                       |  |  |  | 2c. DATE PRONOUNCED DEAD             |  |  |  | 2d. DATE OF DEATH            |  |  |  |
| 3 SEX                                                                     |  |  |  | 4. RACE                                                       |  |  |  | 5. DATE OF BIRTH                                                              |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |  |  |  | 7. IF UNDER 1 YR.            |  |  |  |
| 3 SEX                                                                     |  |  |  | 4. RACE                                                       |  |  |  | 5. DATE OF BIRTH                                                              |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |  |  |  | 7. IF UNDER 1 YR.            |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                 |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?                                  |  |  |  | 8. MARRIED                                                                    |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |  | 10. CITY OR TOWN OF DEATH    |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                 |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?                                  |  |  |  | 8. MARRIED                                                                    |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |  | 10. CITY OR TOWN OF DEATH    |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                             |  |  |  | 13a. STREET ADDRESS                  |  |  |  | 13b. CITY LIMITS?            |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                             |  |  |  | 13a. STREET ADDRESS                  |  |  |  | 13b. CITY LIMITS?            |  |  |  |
| 14. FATHER'S NAME                                                         |  |  |  | 15. MOTHER'S MAIDEN NAME                                      |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                  |  |  |  | 16b. SOCIAL SECURITY NO.             |  |  |  | 17. INFORMANT                |  |  |  |
| 14. FATHER'S NAME                                                         |  |  |  | 15. MOTHER'S MAIDEN NAME                                      |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                  |  |  |  | 16b. SOCIAL SECURITY NO.             |  |  |  | 17. INFORMANT                |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) |  |  |  | 19a. DATE OF OPERATION                                        |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                             |  |  |  | 20. AUTOPSY?                         |  |  |  | 21a. EXTERNAL CAUSE WAS      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) |  |  |  | 19a. DATE OF OPERATION                                        |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                             |  |  |  | 20. AUTOPSY?                         |  |  |  | 21a. EXTERNAL CAUSE WAS      |  |  |  |
| 21a. EXTERNAL CAUSE WAS                                                   |  |  |  | 21b. TIME OF INJURY                                           |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  | 21d. INJURY OCCURRED                 |  |  |  | 21e. PLACE OF INJURY         |  |  |  |
| 21a. EXTERNAL CAUSE WAS                                                   |  |  |  | 21b. TIME OF INJURY                                           |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  | 21d. INJURY OCCURRED                 |  |  |  | 21e. PLACE OF INJURY         |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on |  |  |  | Autopsy                                                       |  |  |  | Inspection                                                                    |  |  |  | Inquiry                              |  |  |  | and in my opinion            |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on |  |  |  | Autopsy                                                       |  |  |  | Inspection                                                                    |  |  |  | Inquiry                              |  |  |  | and in my opinion            |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL                                           |  |  |  | 23b. DATE                                                     |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY                                            |  |  |  | 23d. LOCATION                        |  |  |  | 24. FUNERAL DIRECTOR         |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL                                           |  |  |  | 23b. DATE                                                     |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY                                            |  |  |  | 23d. LOCATION                        |  |  |  | 24. FUNERAL DIRECTOR         |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR                                             |  |  |  | 25b. REGISTRAR'S SIGNATURE                                    |  |  |  | 26. DATE REC'D. BY REGISTRAR                                                  |  |  |  | 26b. REGISTRAR'S SIGNATURE           |  |  |  | 27. DATE REC'D. BY REGISTRAR |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR                                             |  |  |  | 25b. REGISTRAR'S SIGNATURE                                    |  |  |  | 26. DATE REC'D. BY REGISTRAR                                                  |  |  |  | 26b. REGISTRAR'S SIGNATURE           |  |  |  | 27. DATE REC'D. BY REGISTRAR |  |  |  |



REPRINTED

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83

27762

1- FOR  
STATE  
REGISTRAR

REG. NO.

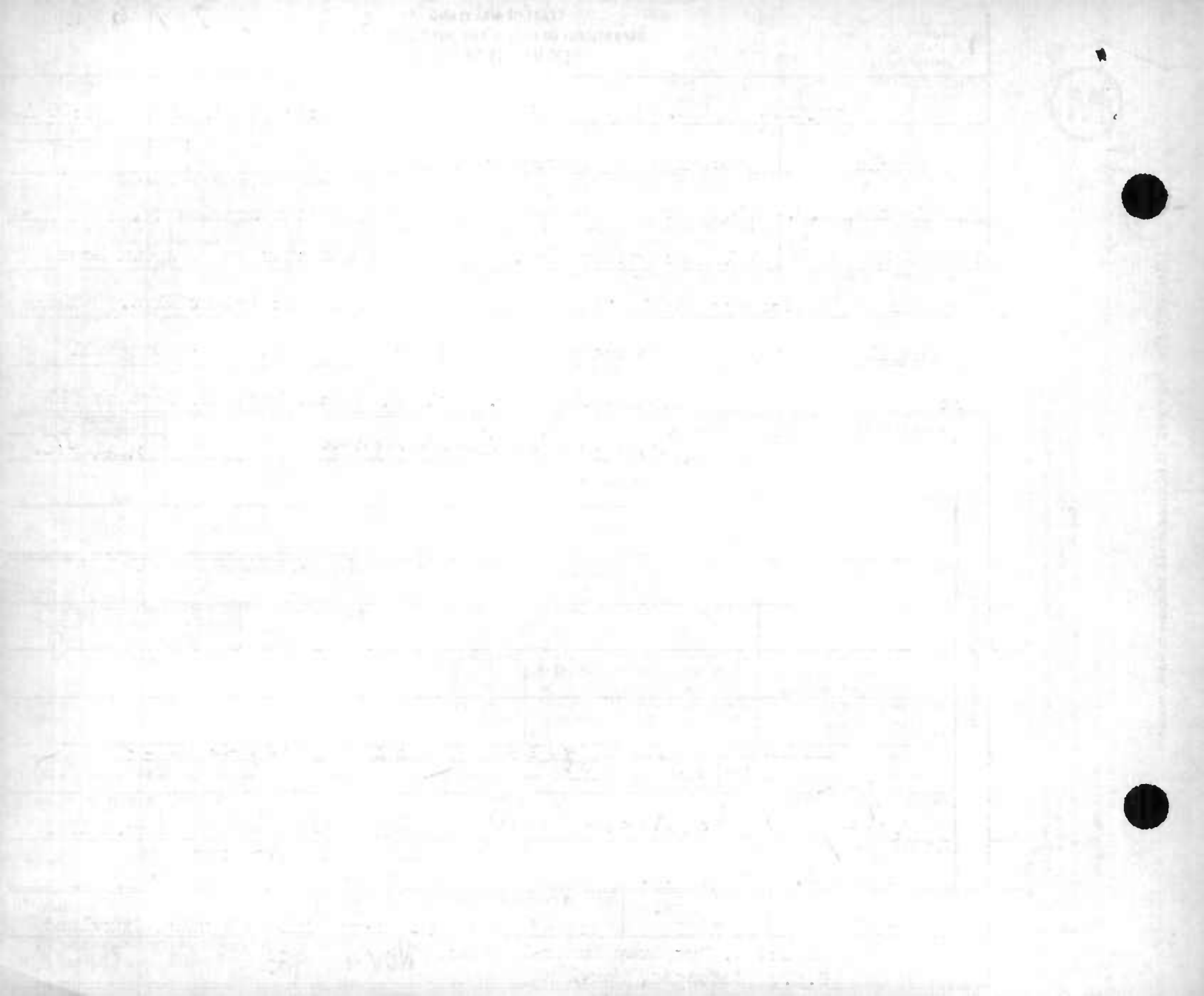
|                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                          |                                                                |                                                                                                                                                             |                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Margaret E. Lynch</b>                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 30, 1983</b> |                                                                                                                                                             | 2b. HOUR<br><b>3:00 AM</b> |  |
| 3. SEX<br><b>Female</b>                                                                                                             |  | 4. RACE<br><b>Caucasian</b>                                                                                                                                                                                                                                                                                                                                              |                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>November 9, 1918</b>                                                                                               |                            |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.                                                                                   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                                                                                                                                                                                                                                                           |                                                                | IF UNDER 24 HRS.<br>HOURS MIN.                                                                                                                              |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, D.C.</b>                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                                                                                                                                                                                                                                                     |                                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD</b>                                                                |  | 10. CITY OR TOWN OF DEATH<br><b>Cabin John</b>                                                                                                                                                                                                                                                                                                                           |                                                                | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7816 Mac Arthur Blvd.</b>                   |                            |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                                                                                                                                                                                                                                                                                                     |                                                                | 13a. STATE<br><b>Maryland</b>                                                                                                                               |                            |  |
| 13b. COUNTY<br><b>Montgomery</b>                                                                                                    |  | 13c. CITY OR TOWN<br><b>Cabin John</b>                                                                                                                                                                                                                                                                                                                                   |                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |                            |  |
| 13e. STREET ADDRESS<br><b>7816 Mac Arthur Blvd.</b>                                                                                 |  | 13f. CITY OR TOWN<br><b>20818</b>                                                                                                                                                                                                                                                                                                                                        |                                                                | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Roy Robertson</b>                                                                                       |                            |  |
| 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine Edith Campbell</b>                                                    |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                        |                                                                | 16b. SOCIAL SECURITY NO.<br><b>214-12-7675</b>                                                                                                              |                            |  |
| 17. INFORMANT<br>ADDRESS<br><b>Mr. Alvin D. Lynch, Husband, Same as #13</b>                                                         |  | 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pancreatic Carcinoma</b><br><b>1579</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>months</b>                                                                                               |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |                                                                                                                                                                                                                                                                                                                                                                          |                                                                |                                                                                                                                                             |                            |  |
| 19a. DATE OF OPERATION                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                         |                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 |                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                            |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                      |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                             |                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                            |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                   |  | 22a. I certify that (1) (this hospital) attended the deceased from <b>9/23</b> , 19 <b>82</b> , to <b>10/30</b> , 19 <b>83</b> , that (1) (we) last saw the deceased alive on <b>10/20</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (and) (I) did not) view the body after death.  |                                                                | 22c. DATE SIGNED<br><b>Nov. 1, 1983</b>                                                                                                                     |                            |  |
| 22b. SIGNATURE<br><b>Stephen J. Newman, M.D.</b>                                                                                    |  | 22d. ADDRESS<br><b>11500 Old Georgetown Road<br/>Rockville, Maryland 20852</b>                                                                                                                                                                                                                                                                                           |                                                                | 22e. DATE SIGNED<br><b>Nov. 1, 1983</b>                                                                                                                     |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                       |  | 23b. DATE<br><b>Nov. 3, 1983</b>                                                                                                                                                                                                                                                                                                                                         |                                                                | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cemetery Silver Spring, Maryland</b>                                                                |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                          |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey Funeral Homes,<br/>P.A., Bethesda, Maryland</b>                                                                                                                                                                                                                                                                    |                                                                | 25. DATE REG'D. BY REGISTRAR<br><b>NOV 4 1983</b>                                                                                                           |                            |  |
| 25. REGISTRAR'S SIGNATURE<br><b>John L. Smith</b>                                                                                   |  | 26. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                |                                                                | 27. REGISTRAR'S SIGNATURE                                                                                                                                   |                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

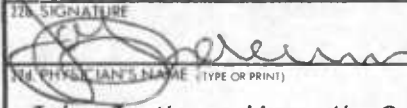
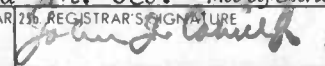




STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                     |                                                                                                                                                             |                                                                                                 |                                                                                      |                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------|
| 1. DECEASED NAME<br>(TYPE & PRINT) <b>MARY E. MacDONALD</b>                                                                                                                                                                                                                                                                                                           |                                                                                                                                                     |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>OCT. 29 1983</b>                                         |                                                                                      | 2b. HOUR<br><b>12:30 A</b> |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                               | 4. RACE<br><b>Caucasian</b>                                                                                                                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 15, 1914</b>                                                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.                                               | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                            |                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Tennessee</b>                                                                                                                                                                                                                                                                                                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD                                    |                                                                                      |                            |
| 10. CITY OR TOWN OF DEATH<br><b>Kensington</b>                                                                                                                                                                                                                                                                                                                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Kensington Gardens Nursing Home</b> | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Beautician</b>                                                                       | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |                                                                                      |                            |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                         | 13b. COUNTY<br><b>Montgomery</b>                                                                                                                    | 13c. CITY OR TOWN<br><b>Germantown</b>                                                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>12814 Kitchen House Way 20874</b>                          |                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>McCubbins</b>                                                                                                                                                                                                                                                                                                            |                                                                                                                                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                                                                               |                                                                                                 |                                                                                      |                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                         |                                                                                                                                                     | 16b. SOCIAL SECURITY NO.<br><b>212-18-3886</b>                                                                                                              |                                                                                                 | 17. INFORMANT<br><b>Wayne MacDonald Son</b>                                          |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Generalized arteriosclerosis and coronary</b><br>(c) <b>arteriosclerosis</b> |                                                                                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |                                                                                                 |                                                                                      |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                  |                                                                                                                                                     |                                                                                                                                                             |                                                                                                 |                                                                                      |                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                              |                                                                                                                                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                             |                                                                                                                                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 1983</b> to <b>Present 1983</b> , that (I) (we) last saw the deceased alive on <b>Oct 3 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |                                                                                                                                                     |                                                                                                                                                             |                                                                                                 |                                                                                      |                            |
| 22b. SIGNATURE<br><br>PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John J. Merendino, M. D.</b>                                                                                                                                                                                          |                                                                                                                                                     | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                                                 | 22c. DATE SIGNED<br><b>10/29/83</b>                                                  |                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                            |                                                                                                                                                     | 23b. DATE<br><b>Nov. 1, 1983</b>                                                                                                                            |                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>                     |                            |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland Pr. Geo. Maryland</b>                                                                                                                                                                                                                                                                                       |                                                                                                                                                     | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Francis J. Collins</b><br><b>500 University Blvd., W. Silver Spring, Md.</b>                                     |                                                                                                 |                                                                                      |                            |
| 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 2 1983</b>                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                     | 25b. REGISTRAR'S SIGNATURE<br>                                         |                                                                                                 |                                                                                      |                            |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Deaths may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



*[Faint, illegible text, likely bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                   |  | REG. NO.                                                                                                                                  |  |                                                                                                                         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                   |  | 20. DATE OF DEATH MONTH DAY YEAR                                                                                                          |  |                                                                                                                         |  |
| DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>RICHARD Marshall MACE</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                   |  | 20. DATE OF DEATH MONTH DAY YEAR<br><b>10-6-83</b>                                                                                        |  |                                                                                                                         |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><b>White</b>                                                                                                           |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3 07 18</b>                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><b>65</b>                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.D. DAKOTA</b>                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                     |  | 8. MARRIED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVERSPRING</b>                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSP.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Pharmaceutical</b>                                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Squibb Co</b>                                                                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                              |  | 13c. CITY OR TOWN<br><b>Montgomery</b>                                                                                            |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                              |  | 13e. STREET ADDRESS<br><b>20115 HOBHILL WAY</b>                                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>James M Mace</b>                                                                                                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Alma nm Anderson</b>                                                             |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>WW11 Yes WW 11</b>                     |  |                                                                                                                         |  |
| 16b. SOCIAL SECURITY NO.<br><b>504-10-0436</b>                                                                                                                                                                                                                                                                                                                                                     |  | 17. INFORMANT<br><b>Peter M. Mace</b>                                                                                             |  | 17. ADDRESS<br><b>4701 Conn Ave N.W. D.C. Apt 209 20008</b>                                                                               |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1919</b> IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Brain Tumor (Glioblastoma)</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>5 mo.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |                                                                                                                                   |  |                                                                                                                                           |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>none</b>                                                                                                                                                                                                                                                       |  |                                                                                                                                   |  |                                                                                                                                           |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                    |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                            |  | 21d. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                            |  | 21g. LOCATION CITY OR TOWN COUNTY STATE                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-</b> 19 <b>83</b> , to <b>10-6</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>10-6</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                         |  |                                                                                                                                   |  |                                                                                                                                           |  |                                                                                                                         |  |
| 22b. SIGNATURE<br><b>Frederick J. Barr</b> M.D.                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                   |  | 22c. DATE SIGNED                                                                                                                          |  |                                                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Frederick J. Barr MD</b>                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                   |  | 22e. ADDRESS<br><b>4500 Cole Ave. College Park, Md.</b>                                                                                   |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>Oct. 10, 1983</b>                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>                                                                         |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Suitland Pr. Geo. Md.</b>                                                 |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>W. W. Chambers Co, 8655 Georgia Ave, SIL. SPRING</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>13 1983</b>                                                                                           |  |                                                                                                                         |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                   |  |                                                                                                                                           |  |                                                                                                                         |  |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                         |                                                                                                                                                             |                                                                                                                                                      | REG. NO.                                                                             |                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                         |                                                                                                                                                             | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNE MADEOY</b>                                                                                               |                                                                                      |                                                                                                                            |
| 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10-3-83</b>                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                         |                                                                                                                                                             | 2b. HOUR<br><b>10:08</b> M                                                                                                                           |                                                                                      |                                                                                                                            |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                        | 4. RACE<br><b>WHITE</b>                                                                                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JULY 1, 1904</b>                                                                                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS                                                                                                     |                                                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>RUSSIA</b>                                                                                                                                                                                                                                                                                                                                                                                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b>                                                                                 |                                                                                      |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>                                                                                                                                                                                                                                                                                                                                                                                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                                                                 |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>                                                                       |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>MONTGOMERY</b> 13c. CITY OR TOWN <b>SILVER SPRING</b>                                                                                                                                                                                                                                                     |                                                                                                                                         |                                                                                                                                                             | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS<br><b>1702 HAMPSHIRE GREEN LANE</b> |                                                                                      |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>PERCY WOOL</b>                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>IRENE</b>                                                                                        |                                                                                      |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>NO (NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br><b>215-48-3220</b>                                                                                                              | 17. INFORMANT<br><b>1702 HAMPSHIRE GREEN LANE<br/>ROSALIE MADEOY, SILVER SPRING, MARYLAND</b>                                                        |                                                                                      |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Ischemic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerosis - hypertension</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>10 years</b><br><b>30 years</b> |                                                                                                                                         |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>Cerebral thrombosis</b>                                                                                                                                                                                                                                                                             |                                                                                                                                         |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                       |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>19 56</b> to <b>October 3, 19 83</b> , that (I) (we) last saw the deceased alive on <b>October 3, 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                   |                                                                                                                                         |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                                                                                                                            |
| 22b. SIGNATURE<br><b>Arthur S. Bresler M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                         | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                                                                                                                                      | 22c. DATE SIGNED<br><b>1983<br/>OCTOBER 4,</b>                                       |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. ARTHUR S. BRESLER, M. D.</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                         | 22e. ADDRESS<br><b>10881 LOCKWOOD DRIVE<br/>SILVER SPRING, MARYLAND 20901</b>                                                                               |                                                                                                                                                      |                                                                                      |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                         | 23b. DATE<br><b>10/5/1983</b>                                                                                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MOUNT LEBANON CEMETERY ADELPHI, GEORGE'S, MARYLAND</b>                                                      |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>PRINCE GEORGE'S, MARYLAND</b>                                                   |
| 24. FUNERAL HOME<br><b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                         | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 7 1983</b>                                                                                                          |                                                                                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                                  |                                                                                                                            |
| 232 CARROLL STREET, N. W., WASHINGTON, D. C.                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                         |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                                                                                                                            |

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Handwritten notes at the top of the page, including the word "Hill" and other illegible scribbles.

Handwritten notes in the middle section, including the phrase "Date of arrival" and other illegible text.

Handwritten notes at the bottom of the page, including the word "Hill" and other illegible scribbles.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                    |                                                                                                                                    |                                                                                                                                                             |                                                                                            |                                                                                                 |                                   |
|------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JAMES MICHAEL MALEY</b>                  |                                                                                                                                    |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 20 1983</b>                              |                                                                                                 | 2b. HOUR<br><b>11:40A</b>         |
| 3. SEX<br><b>MALE</b>                                                              | 4. RACE<br><b>CAUCASIAN</b>                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APRIL 19 1908</b>                                                                                                  |                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.                                               |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>                                                                               | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD                                    |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NAVAL HOSPITAL</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED US NAVY</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br><b>MARYLAND</b>                                                      |                                                                                                                                    | 13b. COUNTY<br><b>MONTGOMERY</b>                                                                                                                            | 13c. CITY OR TOWN<br><b>BETHESDA</b>                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |
| 14. FATHER'S NAME<br><b>JOHN NMN MALEY</b>                                         |                                                                                                                                    |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br><b>JULIA NMN BARRY<sup>ST</sup></b>                            |                                                                                                 |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b> |                                                                                                                                    | 16b. SOCIAL SECURITY NO.<br><b>1941-1965 087-12-9191</b>                                                                                                    |                                                                                            | 17. INFORMANT<br>ADDRESS<br><b>5225 POOKS HILL RD BETHESDA, MD 20813</b>                        |                                   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **MALIGNANT FIBROUS HISTIOCYTOMA**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

|                                                                                                                                 |  |                                                                        |  |                                                                                      |                                                                                                                                          |
|---------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |                                                                                                                                          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                                          |

22a. I certify that (I) (this hospital) attended the deceased from **18 OCTOBER, 1983**, to **20 OCTOBER, 1983**, that (I) (we) last  
saw the deceased alive on **20 OCTOBER, 1983**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

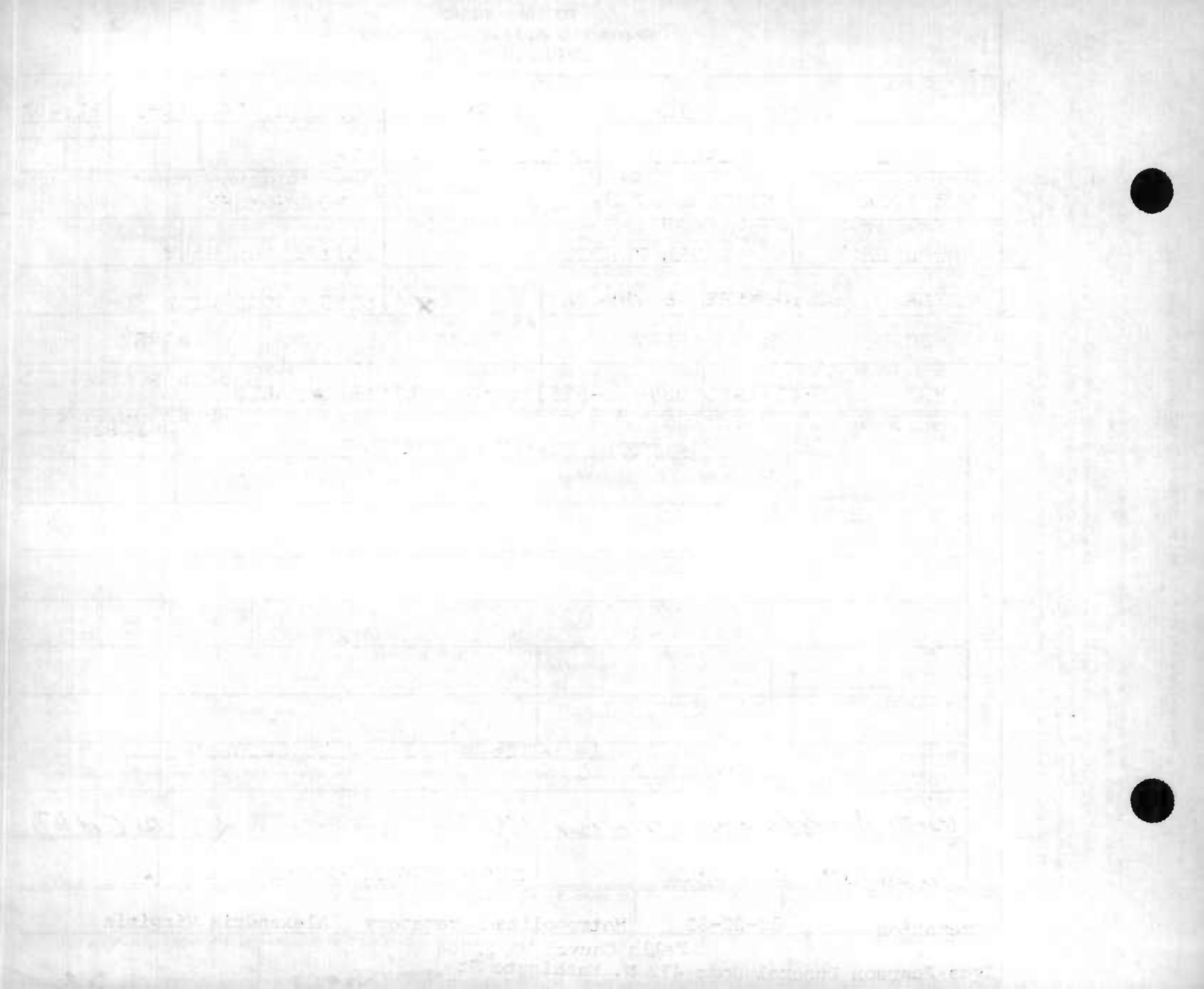
|                                                                            |  |                                                          |  |                                      |  |
|----------------------------------------------------------------------------|--|----------------------------------------------------------|--|--------------------------------------|--|
| 22b. SIGNATURE<br><i>V. Aletich MD</i>                                     |  | DEGREE<br><b>MD</b>                                      |  | 22c. DATE SIGNED<br><b>21 Oct 83</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>V. ALETICH, LCDR, MC, USNR</b> |  | 22e. ADDRESS<br><b>NAVAL HOSPITAL BETHESDA, MD 20814</b> |  |                                      |  |

|                                                                                       |                              |                                                                     |                                                                          |
|---------------------------------------------------------------------------------------|------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                      | 23b. DATE<br><b>10-22-83</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crematory</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Alexandria Virginia</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ives-Pearson Funeral Home 472 N. Washington St</b> |                              | 25a. DATE REC'D. BY REGISTRAR                                       | 25b. REGISTRAR'S SIGNATURE                                               |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                             |                                                                     |                              |                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------|------------------------------------------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                       |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                           |                                                                     | 2b. HOUR                     |                                                                  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                           |                                                                     | 2b. HOUR                     |                                                                  |
| FIRST MIDDLE LAST<br>MARY ANITA MALLE                                                                                                                                                                                                                                                                                                                              |                                                                                                        | MONTH DAY YEAR<br>10 29 83                                                                                                                                  |                                                                     | 11:15A.M.                    |                                                                  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                             | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR              |                                                                  |
| FEMALE                                                                                                                                                                                                                                                                                                                                                             | CAUCASIAN                                                                                              | MONTH DAY YEAR<br>APRIL 23 1907                                                                                                                             | 76 YRS.                                                             | IF UNDER 24 HRS.             |                                                                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                          | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                              |                                                                  |
| New York                                                                                                                                                                                                                                                                                                                                                           | U.S.A.                                                                                                 |                                                                                                                                                             | MONTGOMERY MD.                                                      |                              |                                                                  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                              |                                                                  |
| SILVER SPRING                                                                                                                                                                                                                                                                                                                                                      | 2508 HAYDEN DRIVE                                                                                      | HOUSEWIFE                                                                                                                                                   |                                                                     |                              |                                                                  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                         | 13b. COUNTY                                                                                            | 13c. CITY OR TOWN                                                                                                                                           | 13d. INSIDE CITY LIMITS?                                            | 13e. STREET ADDRESS          |                                                                  |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                           | MONTGOMERY                                                                                             | SILVER SPRING                                                                                                                                               | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 2508 HAYDEN DRIVE 20902      |                                                                  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                  | 15. MOTHER'S MAIDEN NAME                                                                               | 17. INFORMANT ADDRESS                                                                                                                                       |                                                                     |                              |                                                                  |
| FIRST MIDDLE LAST<br>JOSEPH                                                                                                                                                                                                                                                                                                                                        | FIRST MIDDLE LAST<br>PAPCIAK                                                                           | VICTORIA                                                                                                                                                    |                                                                     |                              |                                                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                                                                                      | 16b. SOCIAL SECURITY NO.                                                                               | 17. INFORMANT ADDRESS                                                                                                                                       |                                                                     |                              |                                                                  |
| NO                                                                                                                                                                                                                                                                                                                                                                 | 093-30-0072                                                                                            | JOAN ELLEN NELSON DAUGHTER SAME AS 13                                                                                                                       |                                                                     |                              |                                                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1539 CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b) MASSIVE EDEMA<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF COLON |                                                                                                        |                                                                                                                                                             |                                                                     |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>MINUTES<br>WEEKS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>VERY LARGE ABDOMINAL TUMOR                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                             |                                                                     |                              |                                                                  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       | 20a. AUTOPSY?                                                                                                                                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                              |                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                         | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                              |                                                                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                     |                              |                                                                  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                       | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                     |                              |                                                                  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/25, 19 83, to 10/29, 19 83, that (I) (we) last saw the deceased alive on 10/25, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                              |                                                                                                        |                                                                                                                                                             |                                                                     |                              |                                                                  |
| 22b. SIGNATURE<br>Richard P. Delaney, M.D.                                                                                                                                                                                                                                                                                                                         |                                                                                                        | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |                                                                     | 22c. DATE SIGNED<br>10/29/83 |                                                                  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard P. Delaney, M.D.                                                                                                                                                                                                                                                                                                  |                                                                                                        | 22e. ADDRESS<br>4323 Havard Street, Silver Spring, Md. 20906                                                                                                |                                                                     |                              |                                                                  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                          | 23b. DATE                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |                              |                                                                  |
| BURIAL                                                                                                                                                                                                                                                                                                                                                             | NOV. 1, 1983                                                                                           | GATE OF HEAVEN                                                                                                                                              | SILVER SPRING MONTGOMERY MD.                                        |                              |                                                                  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                          | 25a. DATE REC'D. BY REGISTRAR                                                                          |                                                                                                                                                             | 25b. REGISTRAR'S SIGNATURE                                          |                              |                                                                  |
| FRANCIS J. COLLINS                                                                                                                                                                                                                                                                                                                                                 | NOV 2 1983                                                                                             |                                                                                                                                                             | John J. G... ..                                                     |                              |                                                                  |
| 500 UNIVERSITY BLVD., W. SILVER SPRING, MD.                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                             |                                                                     |                              |                                                                  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                              |  |                                                                                                                                                                       |                                                                    |                                                                                            |                                                                                                                                                 |                                                                                                                            |                                                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                              |  |                                                                                                                                                                       | REG. NO.                                                           |                                                                                            |                                                                                                                                                 |                                                                                                                            |                                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Sister M. Denyse Maloney, C.S.C.                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                              |  |                                                                                                                                                                       | 2a. DATE OF DEATH<br>October 7, 1983                               |                                                                                            |                                                                                                                                                 | 2b. HOUR<br>10 A.M.                                                                                                        |                                                     |  |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4 RACE<br>Caucasian                                                                                                          |  | 5 DATE OF BIRTH<br>September 20, 1894                                                                                                                                 |                                                                    | 6 AGE (IN YEARS LAST BIRTHDAY)<br>89 YRS                                                   |                                                                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |                                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ireland                                                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                       |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                    | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD                                       |                                                                                                                                                 |                                                                                                                            |                                                     |  |
| 10 CITY OR TOWN OF DEATH<br>Kensington                                                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Angela Hall |  |                                                                                                                                                                       |                                                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Catholic Nun - Teacher |                                                                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                     |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                               |  |                                                                                                                              |  |                                                                                                                                                                       | 13b. CITY OR TOWN<br>Montgomery                                    |                                                                                            | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                 |                                                                                                                            | 13d. STREET ADDRESS<br>5000 Strathmore Avenue 20895 |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Patrick Maloney                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                              |  |                                                                                                                                                                       | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ellen F. McCormick |                                                                                            |                                                                                                                                                 |                                                                                                                            |                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-54-9420                                                       |  | 17 INFORMANT<br>Mother Superior<br>Sister Maureen Patrice Same as 13                                                                                                  |                                                                    |                                                                                            |                                                                                                                                                 |                                                                                                                            |                                                     |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest</u><br><u>4349</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>cerebral infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>cerebral &amp; coronary A.S.V.D.</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>15'</u><br><u>1 hr</u><br><u>2 yrs</u> |  |                                                                                                                              |  |                                                                                                                                                                       |                                                                    |                                                                                            |                                                                                                                                                 |                                                                                                                            |                                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>C.H.F.</u>                                                                                                                                                                                                                                                                            |  |                                                                                                                              |  |                                                                                                                                                                       |                                                                    |                                                                                            |                                                                                                                                                 |                                                                                                                            |                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                             |  |                                                                                                                                                                       |                                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |                                                                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                        |                                                                    |                                                                                            |                                                                                                                                                 |                                                                                                                            |                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                       |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                     |                                                                    |                                                                                            |                                                                                                                                                 |                                                                                                                            |                                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/6/83</u> to <u>10/7/83</u> , that (I) (we) last saw the deceased alive on <u>10/6</u> 19 <u>83</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                            |  |                                                                                                                              |  |                                                                                                                                                                       |                                                                    |                                                                                            |                                                                                                                                                 |                                                                                                                            |                                                     |  |
| 22b. SIGNATURE<br><u>Stephen N. Jones</u><br>DEGREE                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                              |  |                                                                                                                                                                       | 22c. DATE SIGNED<br>10/7/83                                        |                                                                                            | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                                            |                                                     |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Stephen N. Jones, M.D.                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                              |  |                                                                                                                                                                       | 22f. ADDRESS<br>809 Viers Mill Rd. Rockville, Md.                  |                                                                                            |                                                                                                                                                 |                                                                                                                            |                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br>Oct. 11, 1983                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet Cemetery                                                                                                             |                                                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Washington D. C.                             |                                                                                                                                                 |                                                                                                                            |                                                     |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Francis J. Collins                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                              |  |                                                                                                                                                                       | 25a. DATE REC'D. BY REGISTRAR<br>OCT 13 1983                       |                                                                                            | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Smith</u>                                                                                              |                                                                                                                            |                                                     |  |
| 500 University Blvd., W. Silver Spring, Md.                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                              |  |                                                                                                                                                                       |                                                                    |                                                                                            |                                                                                                                                                 |                                                                                                                            |                                                     |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN FOUR HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                        |                                                                                                                                                                                                                                                            |                                                                                                                                                             |                                                                                    |                                                                                                                            |                                                                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Laurence E. Mann</b>                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                        | 2a. DATE KNOWN OF DEATH<br>MONTH <b>10</b> DAY <b>24</b> YEAR <b>1983</b>                                                                                                                                                                                  |                                                                                                                                                             |                                                                                    | 2b. HOUR<br>M <b>11:27</b> P <b>11:27</b>                                                                                  |                                                                                                 |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                  | 4. RACE<br><b>Negro</b> | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>7</b> YEAR <b>1936</b>                                                                      | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>46</b> YRS.                                                                                                                                                                                                          | IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b>                                                                                                             | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN <b>0</b>                                    | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>10</b> DAY <b>24</b> YEAR <b>1983</b>                                                 |                                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Guyana</b>                                                                                                                                                                                                                                                                                                                                                                             |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Guyana</b>                                                                                          |                                                                                                                                                                                                                                                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD</b>                                                       |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>                                                                                                                                                                                                                                                                                                                                                                                           |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |                                                                                                                                                                                                                                                            |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Consultant</b> |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Economics</b>                                           |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                        | 13b. CITY OR TOWN<br><b>Montgomery</b>                                                                                                                                                                                                                     |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Kensington</b>                                             |                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <b>Richard</b> MIDDLE <b>A.</b> LAST <b>Mann</b>                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Hettie</b> MIDDLE <b>Eileen</b> LAST <b>Cannings</b>                                                                                                                                                                  |                                                                                                                                                             |                                                                                    | 16. SOCIAL SECURITY NO.<br><b>No Number</b>                                                                                |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                        | 16b. SOCIAL SECURITY NO.<br><b>No Number</b>                                                                                                                                                                                                               |                                                                                                                                                             |                                                                                    | 17. INFORMANT (Sister)<br><b>Lesley King</b>                                                                               |                                                                                                 |  |
| 17. ADDRESS<br><b>3506 Astoria Ct. Zip:20895</b>                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                        | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                                                                                                                                                             |                                                                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |                                                                                                 |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                        |                                                                                                                                                                                                                                                            |                                                                                                                                                             |                                                                                    |                                                                                                                            |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                                                                                                                          |                                                                                                                                                             |                                                                                    | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                        |                                                                                                 |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                        | 21b. TIME OF INJURY<br>HOUR <b>9:15 P.M.</b> MONTH <b>10-24-</b> YEAR <b>1983</b>                                                                                                                                                                          |                                                                                                                                                             |                                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)<br><b>Self-inflicted.</b>                    |                                                                                                 |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>house</b>                                                                                                                                                                                |                                                                                                                                                             |                                                                                    | 21f. LOCATION<br>STREET <b>4977 Battery Lane,</b> CITY OR TOWN <b>Bethesda,</b> COUNTY <b>Montgomery,</b> STATE <b>Md.</b> |                                                                                                 |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                         |                                                                                                                                        |                                                                                                                                                                                                                                                            |                                                                                                                                                             |                                                                                    |                                                                                                                            |                                                                                                 |  |
| ACTUAL SIGNATURE<br><b>Thomas D. Smith, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                        | TITLE (SPECIFY)<br><b>Deputy Chief</b>                                                                                                                                                                                                                     |                                                                                                                                                             |                                                                                    | DATE SIGNED<br><b>10-25-83</b>                                                                                             |                                                                                                 |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                        | ADDRESS<br><b>111 Penn St., Balto., Md. 21201</b>                                                                                                                                                                                                          |                                                                                                                                                             |                                                                                    |                                                                                                                            |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                        | 23b. DATE<br><b>October 28, 1983</b>                                                                                                                                                                                                                       |                                                                                                                                                             |                                                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cemetery</b>                                                       |                                                                                                 |  |
| 23d. LOCATION<br>CITY OR TOWN <b>Silver Spring</b> COUNTY <b>Maryland</b> STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                        | 24. FUNERAL DIRECTOR<br>NAME <b>Robert A. Pumphrey Funeral Homes, P.A., 7557 Wisconsin Ave, Bethesda, Maryland</b>                                                                                                                                         |                                                                                                                                                             |                                                                                    | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 15 1983</b>                                                                        |                                                                                                 |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carney</b>                                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                        |                                                                                                                                                                                                                                                            |                                                                                                                                                             |                                                                                    |                                                                                                                            |                                                                                                 |  |



CONFIDENTIAL

CONFIDENTIAL



CONFIDENTIAL

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                    |                                                            |                                                                                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                                                       |                                                                  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>NAN MANNING</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>OCTOBER 22 1983</b> |                                                                                                                                                             | 2b. HOUR<br><b>5:45 P<sub>M</sub></b>                                                |                                                                                                                                            |                                                                                                                                       |                                                                  |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>CAUCASIAN</b>                                                                                                        |                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>SEPTEMBER 13 1921</b>                                                                                              |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.                                                                                          |                                                                                                                                       | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>GEORGIA</b>                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>                                                                               |                                                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                                                              |                                                                                                                                       |                                                                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NAVAL HOSPITAL</b> |                                                            |                                                                                                                                                             |                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MERCHANDISING</b>                                                   |                                                                                                                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RETAIL STORES</b>        |  |
| 13a. STATE<br><b>VIRGINIA</b>                                                                                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY<br><b>ARLINGTON</b>                                                                                                    |                                                            | 13c. CITY OR TOWN<br><b>ARLINGTON</b>                                                                                                                       |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                            |                                                                                                                                       | 13e. STREET ADDRESS<br><b>2111 JEFFERSON DAVIS HIGHWAY</b>       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GROVER CLEVELAND MOORE</b>                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                    |                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH NEWSOME</b>                                                                                       |                                                                                      |                                                                                                                                            |                                                                                                                                       |                                                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br><b>263-16-1870</b>                                                                                     |                                                            | 17. INFORMANT ADDRESS<br><b>RAYMOND E. MANNING, 2111 JEFFERSON DAVIS HIGHWAY, ARLINGTON, VA 22202</b>                                                       |                                                                                      |                                                                                                                                            |                                                                                                                                       |                                                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA AND SEPSIS</b><br>2041<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC LYMPHOCYTIC LEUKEMIA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |                                                                                                                                    |                                                            |                                                                                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.                                                                                                                                                                                                                                                    |  |                                                                                                                                    |                                                            |                                                                                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                                                       |                                                                  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |                                                            |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                         |                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                      |                                                                                                                                            |                                                                                                                                       |                                                                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                                                                                            |                                                                                                                                       |                                                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 16</b> , 19 <b>83</b> , to <b>OCTOBER 22</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>OCTOBER 22</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.    |  |                                                                                                                                    |                                                            |                                                                                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                                                       |                                                                  |  |
| 22b. SIGNATURE<br><b>R. L. Sollock</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                    |                                                            | DEGREE<br><b>LCDR, MC, USN</b>                                                                                                                              |                                                                                      | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                                                       | 22c. DATE SIGNED<br><b>24 Oct 83</b>                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. L. SOLLOCK, LCDR, MC, USN</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                    |                                                            | 22e. ADDRESS<br><b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>                                                   |                                                                                      |                                                                                                                                            |                                                                                                                                       |                                                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br><b>Oct. 26 1983</b>                                                                                                   |                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington Nat'l Cem.</b>                                                                                           |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlington, Virginia</b>                                                                   |                                                                                                                                       |                                                                  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ives-Pearson F. H. Arlington, VA. 22201</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                    |                                                            | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 28 1983</b>                                                                                                         |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                           |                                                                                                                                       |                                                                  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



EC 0011

CHIEF

Form with multiple sections and fields, mostly illegible due to fading. Visible text includes:

- Top section: "UNITED STATES DEPARTMENT OF JUSTICE"
- Section 1: "NAME OF PERSON"
- Section 2: "ADDRESS"
- Section 3: "CITY"
- Section 4: "STATE"
- Section 5: "ZIP CODE"
- Section 6: "DATE OF BIRTH"
- Section 7: "SEX"
- Section 8: "RACE"
- Section 9: "EDUCATION"
- Section 10: "OCCUPATION"
- Section 11: "MILITARY SERVICE"
- Section 12: "CRIMINAL RECORD"
- Section 13: "REMARKS"

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                  |  |                                                                               |                                                                                                                                                             |                                                                                                                           |                                                                       |                                                                                     |                                                                                   | REG. NO.                                           |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Susana I. Matheus</b>                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                  |  |                                                                               |                                                                                                                                                             | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10 12 1983</b>                 |                                                                       |                                                                                     | 2b. HOUR <b>10:54</b>                                                             |                                                    |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>July 5, 1937</b>                                                                                           |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>46</b> YRS.                             | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                                                                 | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>10 12 1983</b>                                                              |                                                                       |                                                                                     | 2d. HOUR <b>10:54</b>                                                             |                                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South America</b>                                                                                                                                                                                                                                                                                                                                                                        |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                       |  |                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, Md.</b> |                                                                                     |                                                                                   |                                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Onley</b>                                                                                                                                                                                                                                                                                                                                                                                                |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  |                                                                               |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secty.</b>                                            |                                                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>State of Md.</b>                            |                                                                                   |                                                    |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                  |  |                                                                               |                                                                                                                                                             | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                           |                                                                       | 13b. STREET ADDRESS<br><b>3030 Hewitt Ave. # 10 20906</b>                           |                                                                                   |                                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Vladimir P. Korolevich</b>                                                                                                                                                                                                                                                                                                                                                                  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elena DiDonata</b>                                                                           |  |                                                                               |                                                                                                                                                             | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>N/A</b> (IF YES, GIVE WAR OR DATES) <b>N/A</b>   |                                                                       |                                                                                     |                                                                                   |                                                    |  |
| 16b. SOCIAL SECURITY NO.<br><b>213-56-7598</b>                                                                                                                                                                                                                                                                                                                                                                                           |                         | 17. INFORMANT<br><b>Vladimir P. Korolevich-father-</b>                                                                                           |  |                                                                               |                                                                                                                                                             | ADDRESS <b>3234 Hewitt Ave., S.S. Md.</b>                                                                                 |                                                                       |                                                                                     |                                                                                   |                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Stab Wound of Chest</b><br>9660<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF                                                                        |                         |                                                                                                                                                  |  |                                                                               |                                                                                                                                                             |                                                                                                                           |                                                                       |                                                                                     |                                                                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                  |  |                                                                               |                                                                                                                                                             |                                                                                                                           |                                                                       |                                                                                     |                                                                                   |                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                             |                                                                                                                                                             |                                                                                                                           |                                                                       | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                   |                                                    |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR <b>8:50</b> P.M. MONTH DAY YEAR <b>10 12 1983</b> |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>subject was stabbed</b>               |                                                                       |                                                                                     |                                                                                   |                                                    |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home</b>    |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3330 Hewitt Ave., Apt. 10, Silver Spring, Montgomery Co., Md.</b> |                                                                       |                                                                                     |                                                                                   |                                                    |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accidents <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |                                                                                                                                                  |  |                                                                               |                                                                                                                                                             |                                                                                                                           |                                                                       |                                                                                     |                                                                                   |                                                    |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                  |  | TITLE (SPECIFY)<br><b>Assistant</b>                                           |                                                                                                                                                             |                                                                                                                           |                                                                       | MEDICAL EXAMINER<br>DATE SIGNED <b>10-13-83</b>                                     |                                                                                   |                                                    |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                  |  | ADDRESS <b>111 Penn Street</b>                                                |                                                                                                                                                             |                                                                                                                           |                                                                       |                                                                                     |                                                                                   |                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                  |  | 23b. DATE<br><b>10-15-1983</b>                                                |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cemetery</b>                                                      |                                                                       |                                                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Silver Spring Montgomery Md.</b> |                                                    |  |
| 24. FUNERAL DIRECTOR<br><b>Hines/Rinaldi Funeral Home</b>                                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                  |  | ADDRESS <b>11800 N.H. Avenue, Silver Spring, Md.</b>                          |                                                                                                                                                             |                                                                                                                           |                                                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 18 1983</b>                                 |                                                                                   | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Smith</i> |  |

10-15-1983 Date of Review  
11800 N.W. Avenue  
Silver Spring, Md.

10-15-1983 Date of Review  
11800 N.W. Avenue  
Silver Spring, Md.

213-36-1220  
P. Korofayev  
2334 Hewitt Ave.  
Silver Spring, Md.

213-36-1220  
P. Korofayev  
2334 Hewitt Ave.  
Silver Spring, Md.

213-36-1220  
P. Korofayev  
2334 Hewitt Ave.  
Silver Spring, Md.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                               |  |                                                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Elizabeth G. May</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 14 1983</b>                                                                                 |  | 2b. HOUR<br><b>9<sup>15</sup> A.M.</b>                                               |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>white</b>                                                                                                                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 2, 1888</b>                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                 |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>95</b><br>YRS. MONTHS DAYS HOURS MIN.          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Brooke Grove Nursing Home</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                        |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY<br><b>Montgomery</b>                                                                                                              |  | 13c. CITY OR TOWN<br><b>Rockville</b>                                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Philip Holmes</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Stanton</b>                                                                     |  |                                                                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br><b>058-10-6737D</b>                                                                                               |  | 17. INFORMANT<br>ADDRESS<br><b>Robert J. Feeley same as 13c</b>                      |  |
| 18. CAUSE OF DEATH (Enter only one cause (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HYPOSTATIC PNEUMONIA</b><br>4292 DUE TO, OR AS A CONSEQUENCE OF (b) <b>OBSTRUCTIVE BRAIN SYNDROME</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b><br>2/25<br>yes |  |                                                                                                                                               |  |                                                                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>BREAST CARCINOMA</b>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                               |  |                                                                                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                              |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/12/83</b> to <b>10/14/83</b> , that (I) (we) last saw the deceased alive on <b>10/12/83</b> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not examine the body after death.                                                                                                                                     |  |                                                                                                                                               |  |                                                                                      |  |
| 22b. SIGNATURE<br><b>Donald R. Lewis</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  | DEGREE<br><b>MD</b>                                                                                                                           |  | 22c. DATE SIGNED<br><b>10/14/83</b>                                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DONALD R. LEWIS MD</b>                                                                                                                                                                                                                                                                                                                                                                                             |  | 22e. ADDRESS<br><b>OLNEY, Md. 20832.</b>                                                                                                      |  |                                                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIAL INSTRUCTIONS)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br><b>10/17/83</b>                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cemetery</b>                 |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pleasantville, New York</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Tyson Wheeler Funeral Home, Inc.<br/>1331 Rockville Pike Rockville, New York 20852</b>             |  |                                                                                      |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 19 1983</b>                                                                                                                                                                                                                                                                                                                                                                                                            |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Lohr</b>                                                                                             |  |                                                                                      |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                          |  |  |  |  |                                                                                                        |  |                   |  |           | REG. NO.                                                                                                                                                 |         |                                                                     |          |  |                                      |  |  |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--------------------------------------------------------------------------------------------------------|--|-------------------|--|-----------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------|----------|--|--------------------------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                        |  |  |  |  | 2a. DECEASED NAME (TYPE OR PRINT)                                                                      |  | 2b. DATE OF DEATH |  | 2c. MONTH |                                                                                                                                                          | 2d. DAY |                                                                     | 2e. YEAR |  | 2f. HOUR                             |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                               |  |  |  |  | Helen S. McCall                                                                                        |  | October 30, 1983  |  |           |                                                                                                                                                          |         |                                                                     |          |  | M                                    |  |  |  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                        |  |  |  |  | 4. RACE                                                                                                |  |                   |  |           | 5. DATE OF BIRTH                                                                                                                                         |         |                                                                     |          |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |  |  |  |  |
| Female                                                                                                                                                                                                                                                                                                                        |  |  |  |  | Black                                                                                                  |  |                   |  |           | Dec. 28, 1922                                                                                                                                            |         |                                                                     |          |  | 60                                   |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                     |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  |                   |  |           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |         |                                                                     |          |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |  |
| Wash., D.C.                                                                                                                                                                                                                                                                                                                   |  |  |  |  | USA                                                                                                    |  |                   |  |           |                                                                                                                                                          |         |                                                                     |          |  | Montgomery County MD.                |  |  |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                     |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                   |  |           | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |         |                                                                     |          |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |  |  |  |
| Oxon Hill, Md.                                                                                                                                                                                                                                                                                                                |  |  |  |  | 1309 Iverson Street                                                                                    |  |                   |  |           | Housewife                                                                                                                                                |         |                                                                     |          |  |                                      |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                  |  |  |  |  | 13b. INSIDE CITY LIMITS?                                                                               |  |                   |  |           | 13c. STREET ADDRESS                                                                                                                                      |         |                                                                     |          |  |                                      |  |  |  |  |
| Maryland                                                                                                                                                                                                                                                                                                                      |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                               |  |                   |  |           | 1309 Iverson Street                                                                                                                                      |         |                                                                     |          |  | 20745                                |  |  |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                             |  |  |  |  | 15. MOTHER'S MAIDEN NAME                                                                               |  |                   |  |           |                                                                                                                                                          |         |                                                                     |          |  |                                      |  |  |  |  |
| Howard Sparrow                                                                                                                                                                                                                                                                                                                |  |  |  |  | Anna Sharp                                                                                             |  |                   |  |           |                                                                                                                                                          |         |                                                                     |          |  |                                      |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                             |  |  |  |  | 16b. SOCIAL SECURITY NO                                                                                |  |                   |  |           | 17. INFORMANT                                                                                                                                            |         |                                                                     |          |  | ADDRESS                              |  |  |  |  |
| no                                                                                                                                                                                                                                                                                                                            |  |  |  |  | 577 26 9792                                                                                            |  |                   |  |           | Malvin McCall-husband-                                                                                                                                   |         |                                                                     |          |  | 1309 Iverson St                      |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                     |  |  |  |  |                                                                                                        |  |                   |  |           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                             |         |                                                                     |          |  |                                      |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                  |  |  |  |  |                                                                                                        |  |                   |  |           | 5 MIN                                                                                                                                                    |         |                                                                     |          |  |                                      |  |  |  |  |
| IMMEDIATE CAUSE (a) RESPIRATORY ARREST                                                                                                                                                                                                                                                                                        |  |  |  |  |                                                                                                        |  |                   |  |           |                                                                                                                                                          |         |                                                                     |          |  |                                      |  |  |  |  |
| 1619                                                                                                                                                                                                                                                                                                                          |  |  |  |  |                                                                                                        |  |                   |  |           |                                                                                                                                                          |         |                                                                     |          |  |                                      |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                |  |  |  |  |                                                                                                        |  |                   |  |           |                                                                                                                                                          |         |                                                                     |          |  |                                      |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                                                 |  |  |  |  |                                                                                                        |  |                   |  |           |                                                                                                                                                          |         |                                                                     |          |  |                                      |  |  |  |  |
| (b) SQUAMOUS CANCER, LARYNX, ADVANCED                                                                                                                                                                                                                                                                                         |  |  |  |  |                                                                                                        |  |                   |  |           | 6 MOS                                                                                                                                                    |         |                                                                     |          |  |                                      |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                |  |  |  |  |                                                                                                        |  |                   |  |           |                                                                                                                                                          |         |                                                                     |          |  |                                      |  |  |  |  |
| (c)                                                                                                                                                                                                                                                                                                                           |  |  |  |  |                                                                                                        |  |                   |  |           |                                                                                                                                                          |         |                                                                     |          |  |                                      |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                            |  |  |  |  |                                                                                                        |  |                   |  |           |                                                                                                                                                          |         |                                                                     |          |  |                                      |  |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                        |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |                   |  |           | 20a. AUTOPSY?                                                                                                                                            |         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |          |  |                                      |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                               |  |  |  |  |                                                                                                        |  |                   |  |           | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      |         | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |          |  |                                      |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                            |  |  |  |  | 21b. TIME OF INJURY                                                                                    |  |                   |  |           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |         |                                                                     |          |  |                                      |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                               |  |  |  |  | HOUR A.M. MONTH DAY YEAR                                                                               |  |                   |  |           |                                                                                                                                                          |         |                                                                     |          |  |                                      |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                               |  |  |  |  | P.M. 19                                                                                                |  |                   |  |           |                                                                                                                                                          |         |                                                                     |          |  |                                      |  |  |  |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                          |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |                   |  |           | 21f. LOCATION                                                                                                                                            |         |                                                                     |          |  |                                      |  |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                             |  |  |  |  |                                                                                                        |  |                   |  |           | STREET CITY OR TOWN COUNTY STATE                                                                                                                         |         |                                                                     |          |  |                                      |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE 1, 1983, to OCTOBER 30, 1983, that (I) (we) last saw the deceased alive on OCTOBER 11, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |  |  |  |                                                                                                        |  |                   |  |           |                                                                                                                                                          |         |                                                                     |          |  |                                      |  |  |  |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                |  |  |  |  | DEGREE                                                                                                 |  |                   |  |           | 22c. DATE SIGNED                                                                                                                                         |         |                                                                     |          |  |                                      |  |  |  |  |
| Linda D. Green MD                                                                                                                                                                                                                                                                                                             |  |  |  |  |                                                                                                        |  |                   |  |           | 11-2-83                                                                                                                                                  |         |                                                                     |          |  |                                      |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                         |  |  |  |  | 22e. ADDRESS                                                                                           |  |                   |  |           |                                                                                                                                                          |         |                                                                     |          |  |                                      |  |  |  |  |
| Linda D. Green, MD.                                                                                                                                                                                                                                                                                                           |  |  |  |  | 2121 Pennsylvania Avenue, N.W. Wash., DC                                                               |  |                   |  |           |                                                                                                                                                          |         |                                                                     |          |  |                                      |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                     |  |  |  |  | 23b. DATE                                                                                              |  |                   |  |           | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |         |                                                                     |          |  |                                      |  |  |  |  |
| Burial                                                                                                                                                                                                                                                                                                                        |  |  |  |  | Nov 4, 1983                                                                                            |  |                   |  |           | Harmony Memorial Cemetery Landover, Md.                                                                                                                  |         |                                                                     |          |  |                                      |  |  |  |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                          |  |  |  |  | 24a. NAME                                                                                              |  |                   |  |           | 24b. DATE REC'D. BY REGISTRAR                                                                                                                            |         |                                                                     |          |  |                                      |  |  |  |  |
| Stewart                                                                                                                                                                                                                                                                                                                       |  |  |  |  | Funeral Home-4001 Benning Road, S.E.                                                                   |  |                   |  |           | NOV 7 1983                                                                                                                                               |         |                                                                     |          |  |                                      |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                               |  |  |  |  |                                                                                                        |  |                   |  |           | 25. REGISTRAR'S SIGNATURE                                                                                                                                |         |                                                                     |          |  |                                      |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                               |  |  |  |  |                                                                                                        |  |                   |  |           | John J. Gair                                                                                                                                             |         |                                                                     |          |  |                                      |  |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                  |  |                                                                                      |  | REG. NO.                                                                                                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>M. Helen McComb</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  |                                                                                                                                                             |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10-30-83</b>                                              |  |                                                                                      |  | 2b. HOUR<br><b>8:50p M</b>                                                                                                            |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br><b>Caucasian</b>                                                                                                           |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>January 26, 1911</b>                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.                                                |  | IF UNDER 1 YEAR MONTHS DAYS                                                          |  | IF UNDER 24 HRS. HOURS MIN.                                                                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD</b>                              |  |                                                                                      |  |                                                                                                                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Teacher</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Educational</b>                              |  |                                                                                                                                       |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY<br><b>Montgomery</b>                                                                                                      |  | 13c. CITY OR TOWN<br><b>Rockville</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>3 Clemson Court Rockville, Maryland 20850</b>              |  |                                                                                                                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John McComb</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Nettie N/A</b>                                                                                             |  |                                                                                                  |  |                                                                                      |  |                                                                                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br><b>175-22-9458</b>                                                                                                              |  | 17. INFORMANT ADDRESS<br><b>Rita McKee 3 Clemson Court Rockville, Maryland 20850</b>             |  |                                                                                      |  |                                                                                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Longestue Heart Failure - Decompensated</b><br><b>3949</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Intest. Valve Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                  |  |                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Probable Basilar Brain Stroke</b>                                                                                                                                                                                                                                    |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                  |  |                                                                                      |  |                                                                                                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                                  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                        |  |                                                                                                                                       |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                    |  |                                                                                      |  |                                                                                                                                       |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                       |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                         |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                   |  |                                                                                      |  |                                                                                                                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 30 1981</b> to <b>Oct 30 1983</b> , that (I) <del>was</del> lost saw the deceased alive on <b>Oct 30 1983</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did not</del> (did not) view the body after death.                                             |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                  |  |                                                                                      |  |                                                                                                                                       |  |
| 22b. SIGNATURE<br><b>Robert T. Thibodeau</b> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                                                                                                                                                                                               |  |                                                                                                                                       |  |                                                                                                                                                             |  | 22c. DATE SIGNED<br><b>10-31-83</b>                                                              |  |                                                                                      |  |                                                                                                                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT T. THIBODEAU</b>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                       |  |                                                                                                                                                             |  | 22e. ADDRESS<br><b>Rockville, MD 20852</b>                                                       |  |                                                                                      |  |                                                                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                       |  | 23b. DATE<br><b>3, 1983</b>                                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Jefferson Memorial Park Pleasant Hills Pennsylvania</b> |  |                                                                                      |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                               |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Robert A. Pumphrey</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                       |  |                                                                                                                                                             |  | 24b. ADDRESS<br><b>7557 Wisconsin Ave Bethesda, Maryland 20814</b>                               |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 04 1983</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                                                                   |  |

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1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the integrity of the financial system and for the ability to detect and prevent fraud.

2. The second part of the document outlines the specific procedures for recording transactions. It details the steps involved in the accounting process, from the initial entry of data into the system to the final review and approval of the records.

3. The third part of the document discusses the role of the accounting system in providing information to management. It explains how the system can be used to generate reports that help managers make informed decisions about the organization's performance.

4. The fourth part of the document discusses the importance of internal controls in ensuring the accuracy of the accounting records. It describes the various controls that should be in place to prevent errors and fraud, and how these controls should be monitored and maintained.

5. The fifth part of the document discusses the importance of the accounting system in providing information to external stakeholders. It explains how the system can be used to generate reports that are required by regulators and other external parties.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                             |  | 2a. DATE OF DEATH                                                                                      |  | MONTH DAY YEAR                                                                                                                                           |  | 2b. HOUR                                                       |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                   |  | FIRST MIDDLE LAST                                                                                      |  | 10-8-83                                                                                                                                                  |  | 2:45 PM                                                        |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                             |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |                                              |
| Female                                                                                                                                                                                                                                                                                             |  | W                                                                                                      |  | 1-26-88                                                                                                                                                  |  | 85 YRS.                                                        |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |                                              |
| Washington, D.C.                                                                                                                                                                                                                                                                                   |  | U.S.A.                                                                                                 |  | Montgomery MD                                                                                                                                            |  |                                                                |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |                                              |
| Silver Spring                                                                                                                                                                                                                                                                                      |  | Holy Cross                                                                                             |  | Secretary                                                                                                                                                |  | Watergate                                                      |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS?                                       |                                              |
| Maryland                                                                                                                                                                                                                                                                                           |  | Montgomery                                                                                             |  | Silver Spring                                                                                                                                            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME                                                                               |  | 13e. STREET ADDRESS                                                                                                                                      |  |                                                                |                                              |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                  |  | FIRST MIDDLE LAST                                                                                      |  | 1001 Spring Street                                                                                                                                       |  | 20910                                                          |                                              |
| Bartholomew Riordan                                                                                                                                                                                                                                                                                |  | Ellen Sheehan                                                                                          |  |                                                                                                                                                          |  |                                                                |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.                                                                               |  | 17. INFORMANT                                                                                                                                            |  | ADDRESS                                                        |                                              |
| No                                                                                                                                                                                                                                                                                                 |  | 578-36-4176                                                                                            |  | Joseph McGrath                                                                                                                                           |  | 2709 Evans Dr., Sil. Spr Md.                                   |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |                                              |
| IMMEDIATE CAUSE (a) Congestive Heart Failure                                                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |                                              |
| 4100 DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |                                              |
| (b) Acute Myocardial Infarction                                                                                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |                                              |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |                                              |
| (c)                                                                                                                                                                                                                                                                                                |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Sick Sinus Syndrome, Terminal Infection                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                              |
|                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                 |  | 21b. TIME OF INJURY                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                |                                              |
|                                                                                                                                                                                                                                                                                                    |  | HOUR A.M. MONTH DAY YEAR                                                                               |  |                                                                                                                                                          |  |                                                                |                                              |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY                                                                                   |  | 21f. LOCATION                                                                                                                                            |  |                                                                |                                              |
| WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>                                                                                                                                                                                                                        |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                         |  | STREET CITY OR TOWN COUNTY STATE                                                                                                                         |  |                                                                |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/11/83 to 10/17/83, that (I) (we) lost saw the deceased alive on 10/11/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  | 22b. SIGNATURE                                                                                         |  | DEGREE                                                                                                                                                   |  | 22c. DATESIGNED                                                |                                              |
|                                                                                                                                                                                                                                                                                                    |  | Antonio G. Uy                                                                                          |  | MD                                                                                                                                                       |  | 10/8/83                                                        |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                              |  | 22e. ADDRESS                                                                                           |  |                                                                                                                                                          |  |                                                                |                                              |
| ANTONIO G. Uy                                                                                                                                                                                                                                                                                      |  | 831 Univ Blvd E #25 S.S. Md 20903                                                                      |  |                                                                                                                                                          |  |                                                                |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                          |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION                                                  |                                              |
| Burial                                                                                                                                                                                                                                                                                             |  | Oct. 11, 1983                                                                                          |  | Mt. Olivet Cem.                                                                                                                                          |  | Washington, D.C.                                               |                                              |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                               |  | 25a. DATE REC'D. BY REGISTRAR                                                                          |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                               |  |                                                                |                                              |
| FRANCIS J. COLLINS                                                                                                                                                                                                                                                                                 |  | OCT 13 1983                                                                                            |  | John J. Collins                                                                                                                                          |  |                                                                |                                              |
| 500 UNIVERSITY BLVD. WEST                                                                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |                                              |
| SILVER SPRING, MD 20901                                                                                                                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |                                              |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                                                   | REG. NO.                                                                                                                |                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-----------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST                                |                                                                                                                         |                                   |
| HARLAN GIL MCINTURFF                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          | 2a. DATE OF DEATH MONTH DAY YEAR                                                  |                                                                                                                         |                                   |
| OCTOBER 4 1983                                                                                                                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                          | 2b. HOUR                                                                          |                                                                                                                         |                                   |
| 6:43 PM                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          |                                                                                   |                                                                                                                         |                                   |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                        | 4. RACE                                                                                                | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          | 6. AGE (IN YEARS LAST BIRTHDAY)                                                   | IF UNDER 1 YEAR MONTHS DAYS                                                                                             |                                   |
| MALE                                                                                                                                                                                                                                                                                                                                                                          | CAUCASIAN                                                                                              | APRIL 2 1915                                                                                                                                             | 68                                                                                | YRS.                                                                                                                    |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                     | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                              |                                                                                                                         |                                   |
| TENNESSEE                                                                                                                                                                                                                                                                                                                                                                     | UNITED STATES                                                                                          |                                                                                                                                                          | MONTGOMERY MD.                                                                    |                                                                                                                         |                                   |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |                                                                                                                         | 12b. KIND OF BUSINESS OR INDUSTRY |
| BETHESDA                                                                                                                                                                                                                                                                                                                                                                      | NAVAL HOSPITAL                                                                                         |                                                                                                                                                          | RETIRED                                                                           |                                                                                                                         | U.S.M.C.                          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE                                                                                                                                                                                                                                                                       | 13c. CITY OR TOWN                                                                                      | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             | 13e. STREET ADDRESS                                                               |                                                                                                                         |                                   |
| VIRGINIA                                                                                                                                                                                                                                                                                                                                                                      | ARLINGTON                                                                                              | ARLINGTON                                                                                                                                                | 5905 10th ROAD 99999                                                              |                                                                                                                         |                                   |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                           | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                             |                                                                                                                                                          |                                                                                   |                                                                                                                         |                                   |
| WILLIAM DEE MCINTURFF                                                                                                                                                                                                                                                                                                                                                         | MARY LEOTA SCALE                                                                                       |                                                                                                                                                          |                                                                                   |                                                                                                                         |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                             | 16b. SOCIAL SECURITY NO.                                                                               | 17. INFORMANT ADDRESS                                                                                                                                    |                                                                                   |                                                                                                                         |                                   |
| YES                                                                                                                                                                                                                                                                                                                                                                           | 1935-1959                                                                                              | 561-54-2713 BEVERLY MCINTURFF, 5905 10th ROAD, ARLINGTON, VA 22205                                                                                       |                                                                                   |                                                                                                                         |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>SMALL CELL CARCINOMA OF THE LUNG</u><br>1629 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                                                                                                        |                                                                                                                                                          |                                                                                   |                                                                                                                         |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                          |                                                                                   |                                                                                                                         |                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |                                                                                                                                                          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                            | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |                                                                                   |                                                                                                                         |                                   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                   |                                                                                                                         |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER 21, 1983</u> , to <u>OCTOBER 4, 1983</u> , that (I) (we) last saw the deceased alive on <u>OCTOBER 4, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |                                                                                                        |                                                                                                                                                          |                                                                                   |                                                                                                                         |                                   |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                | DEGREE                                                                                                 | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               | 22c. DATE SIGNED                                                                  |                                                                                                                         |                                   |
| <i>Michael D. Canty</i>                                                                                                                                                                                                                                                                                                                                                       | M.D.                                                                                                   |                                                                                                                                                          | 50.1.83                                                                           |                                                                                                                         |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                         |                                                                                                        | 22e. ADDRESS                                                                                                                                             |                                                                                   |                                                                                                                         |                                   |
| MICHAEL D. CANTY, LT, MC, USNR                                                                                                                                                                                                                                                                                                                                                |                                                                                                        | NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814                                                                       |                                                                                   |                                                                                                                         |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                               | 23b. DATE                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       | 23d. LOCATION CITY OR TOWN COUNTY STATE                                           |                                                                                                                         |                                   |
| Burial                                                                                                                                                                                                                                                                                                                                                                        | 10/7/83                                                                                                | Arlington National                                                                                                                                       | Arlington, VA.                                                                    |                                                                                                                         |                                   |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |                                                                                   | 25b. REGISTRAR'S SIGNATURE                                                                                              |                                   |
| Murphy Funeral Home 4510 Wilson Blvd. Arlington, VA                                                                                                                                                                                                                                                                                                                           |                                                                                                        | OCT 7 1983                                                                                                                                               |                                                                                   | <i>John J. Carver</i>                                                                                                   |                                   |

BP





Released by  
Dr. Mayle

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 27777

|                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                |                                                                         |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |  |                                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Marguerite Stuart Mc Namara                                                                                                                                                                                                                                                            |  |                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 9 83                          |                                                                                                                                                             |                                                                                | 2b. HOUR<br>4:55 A.M.                                                                                                                      |                                                                                                 |                                                                                                                            |  |                                                              |  |
| 3. SEX<br>female                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br>Caucasian                                                                                                           |                                                                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 6 1894                                                                                                           |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88<br>YRS.                                                                                              |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                         |  |                                                              |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN)<br>New York                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States                                                                                  |                                                                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY County MD.                                                                              |                                                                                                 |                                                                                                                            |  |                                                              |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SUBURBAN HOSPITAL |                                                                         |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                                                              |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                                                                              |  |                                                              |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                | 13b. COUNTY<br>Montgomery                                               |                                                                                                                                                             | 13c. CITY OR TOWN<br>Kensington                                                |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            |  | 13e. STREET ADDRESS / ZIP CODE<br>4617 Saul Road / zip 20895 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas J. Tobin                                                                                                                                                                                                                                                                                          |  |                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marguerite Beckenbaugh |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |  |                                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no                                                                                                                                                                                                                                             |  |                                                                                                                                | 16b. SOCIAL SECURITY NO.<br>577 09 9114                                 |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br>William S. McNamara see #13                        |                                                                                                                                            |                                                                                                 |                                                                                                                            |  |                                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u><br>4100 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>myocardial infarction</u><br>4 hrs<br>(c) <u>coronary heart disease</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 min |  |                                                                                                                                |                                                                         |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |  |                                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                |  |                                                                                                                                |                                                                         |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |  |                                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                           |  |                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                                                                                                                            |                                                                                                 |                                                                                                                            |  |                                                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                          |  |                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                                            |                                                                                                 |                                                                                                                            |  |                                                              |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>10-9-83</u> to <u>10-9-83</u> , that (I) (we) lost<br>saw the deceased alive on <u>10-9-83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                  |  |                                                                                                                                |                                                                         |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |  |                                                              |  |
| 22b. SIGNATURE<br>Thomas H. Sinderson, MD                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                | DEGREE                                                                  |                                                                                                                                                             |                                                                                | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br>10-9-83                                                                                                |  |                                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>THOMAS G. SINDERSON, MD                                                                                                                                                                                                                                                                                   |  |                                                                                                                                | 22e. ADDRESS<br>11135 ROCKVILLE PIKE, ROCKVILLE, Md. 20850              |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |  |                                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                             |  |                                                                                                                                | 23b. DATE<br>Oct 12, 1983                                               |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven Cemetery                  |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Silver Spring, Maryland                           |                                                                                                                            |  |                                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert A. Pumphrey                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                | ADDRESS<br>Bethesda, Maryland                                           |                                                                                                                                                             | 25a. RECEIVED BY REGISTRAR<br>OCT 13 1983                                      |                                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br>John J. Connelley                                                 |                                                                                                                            |  |                                                              |  |

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                         |                      |                                                                                                                                  |                                                             |                                                                                                                                                          |                                                                                |                                                                                              |                                                                                  |                                                      |                                              | REG. NO. |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>JOHN E. MCSHULSKIS</b>                                                                                                                                                                                                                                                                                                                                                                                      |                      |                                                                                                                                  |                                                             |                                                                                                                                                          |                                                                                | 2a. DATE KNOWN OF DEATH <b>10-16-83</b>                                                      |                                                                                  | 2b. HOUR <b>1:05A</b>                                |                                              |          |  |
| 3. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                              | 4. RACE <b>White</b> | 5. DATE OF BIRTH <b>Apr. 28, 1932</b>                                                                                            | 6. AGE (IN YEARS) <b>51</b>                                 | 7. IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. <b>0</b>                                                                             | 8. IF UNDER 24 HRS. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. <b>0</b> | 2c. DATE PRONOUNCED DEAD <b>10-16-83</b>                                                     |                                                                                  | 2d. HOUR <b>1:05A</b>                                |                                              |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NJ</b>                                                                                                                                                                                                                                                                                                                                                                                             |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                       |                                                             | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>                                |                                                                                  |                                                      |                                              |          |  |
| 10. CITY OR TOWN OF DEATH <b>Bethesda</b>                                                                                                                                                                                                                                                                                                                                                                                                       |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b> |                                                             |                                                                                                                                                          |                                                                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Consultant</b>              |                                                                                  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Health Mgr.</b> |                                              |          |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                      |                      |                                                                                                                                  |                                                             |                                                                                                                                                          |                                                                                | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                  |                                                      |                                              |          |  |
| 13a. STATE <b>Md. 20854</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |                      | 13b. COUNTY <b>Montgomery</b>                                                                                                    |                                                             | 13c. CITY OR TOWN <b>Potomac</b>                                                                                                                         |                                                                                | 13e. STREET ADDRESS <b>10909 Candlelight La. 20854</b>                                       |                                                                                  |                                                      |                                              |          |  |
| 14. FATHER'S NAME <b>John A. McShulskis</b>                                                                                                                                                                                                                                                                                                                                                                                                     |                      |                                                                                                                                  |                                                             |                                                                                                                                                          |                                                                                | 15. MOTHER'S MAIDEN NAME <b>Helen Dargis</b>                                                 |                                                                                  |                                                      |                                              |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No.</b>                                                                                                                                                                                                                                                                                                                                                                   |                      | 16b. SOCIAL SECURITY NO. <b>726-05-4584</b>                                                                                      |                                                             | 17. INFORMANT ADDRESS <b>Constance A. McShulskis Same as # 13</b>                                                                                        |                                                                                |                                                                                              |                                                                                  |                                                      |                                              |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4329</b> IMMEDIATE CAUSE (a) <b>Intracranial hemorrhage</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                                     |                      |                                                                                                                                  |                                                             |                                                                                                                                                          |                                                                                |                                                                                              |                                                                                  |                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                                                                                                                  |                      |                                                                                                                                  |                                                             |                                                                                                                                                          |                                                                                |                                                                                              |                                                                                  |                                                      |                                              |          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                          |                      |                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                                                                                                                                                          |                                                                                |                                                                                              | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                      |                                              |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b> |                                                                                                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                                                                                              |                                                                                  |                                                      |                                              |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                         |                      |                                                                                                                                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                                                                                                                                                          | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                                                                              |                                                                                  |                                                      |                                              |          |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                      |                                                                                                                                  |                                                             |                                                                                                                                                          |                                                                                |                                                                                              |                                                                                  |                                                      |                                              |          |  |
| ACTUAL SIGNATURE <b>Margareta A. Korell</b>                                                                                                                                                                                                                                                                                                                                                                                                     |                      |                                                                                                                                  | TITLE (SPECIFY) <b>Assistant</b>                            |                                                                                                                                                          |                                                                                |                                                                                              | DATE SIGNED <b>10-17-83</b>                                                      |                                                      |                                              |          |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                |                      |                                                                                                                                  | ADDRESS <b>111 Penn Street</b>                              |                                                                                                                                                          |                                                                                |                                                                                              |                                                                                  |                                                      |                                              |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                         |                      |                                                                                                                                  | 23b. DATE <b>10/19/83</b>                                   |                                                                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cem.</b>                      |                                                                                              | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Wash., DC</b>                         |                                                      |                                              |          |  |
| 24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b>                                                                                                                                                                                                                                                                                                                                                                                     |                      |                                                                                                                                  |                                                             |                                                                                                                                                          |                                                                                | 25a. DATE REC'D. BY REGISTRAR <b>OCT 24 1983</b>                                             |                                                                                  | 25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>     |                                              |          |  |
| ADDRESS <b>5130 Wisc. Ave. N.W. Wash., D.C.</b>                                                                                                                                                                                                                                                                                                                                                                                                 |                      |                                                                                                                                  |                                                             |                                                                                                                                                          |                                                                                |                                                                                              |                                                                                  |                                                      |                                              |          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                   |  |  |  | REG. NO. 8 3 2 7 7 7 9                                                                                                     |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|----------------------------------------------------------------------------------------------------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                 |  |  |  | 2a. DATE OF DEATH                                                                                                          |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) ANNA C. MENDELSON                                                                                                                                                                                                                                                     |  |  |  | 2b. DATE OF DEATH MONTH DAY YEAR OCTOBER 5, 1983                                                                           |  |  |  |
| 3 SEX FEMALE                                                                                                                                                                                                                                                                                           |  |  |  | 2b. HOUR 11:30A                                                                                                            |  |  |  |
| 4 RACE WHITE                                                                                                                                                                                                                                                                                           |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 61                                                                                         |  |  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 17, 1921                                                                                                                                                                                                                                                      |  |  |  | 8. IF UNDER 1 YEAR MONTHS DAYS                                                                                             |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.                                                                                                                                                                                                                                             |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                        |  |  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>                                                                                                                                               |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.                                                                 |  |  |  |
| 10. CITY OR TOWN OF DEATH SILVER SPRING                                                                                                                                                                                                                                                                |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKKEEPER                                                                                                                                                                                                                               |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY PRIVATE                                                                                  |  |  |  |
| 13a. STATE MARYLAND                                                                                                                                                                                                                                                                                    |  |  |  | 13b. CITY OR TOWN SILVER SPRING                                                                                            |  |  |  |
| 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                           |  |  |  | 13d. STREET ADDRESS 20910 9039 SLIGO CREEK PARKWAY                                                                         |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST LEO COLEMAN                                                                                                                                                                                                                                                        |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE UGEL                                                                       |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN? NO                                                                                                                                                                                                                                    |  |  |  | 16b. SOCIAL SECURITY NO. 578-12-1654                                                                                       |  |  |  |
| 17. INFORMANT ADDRESS 713 BONMARK COURT GERMANTOWN, MARYLAND                                                                                                                                                                                                                                           |  |  |  | PHILIP MENDELSON,                                                                                                          |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Lung CANCER, 1629<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Lung Abscess                                                         |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs                                                                         |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                    |  |  |  |                                                                                                                            |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                 |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                           |  |  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                      |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>    |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                     |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                       |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                                                                                                                                                                         |  |  |  | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                        |  |  |  |
| 21e. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                         |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                             |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 12/19/82, to 10/5/83, that (1) (we) last saw the deceased alive on 10/4/83, and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |  |  |  |                                                                                                                            |  |  |  |
| 22b. SIGNATURE Peter B. Sherer MD                                                                                                                                                                                                                                                                      |  |  |  | 22c. DATE SIGNED 10/5/83                                                                                                   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. PETER B. SHERER                                                                                                                                                                                                                                              |  |  |  | 22e. ADDRESS 3947 FERRARA DRIVE WHEATON, MARYLAND 20906                                                                    |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL                                                                                                                                                                                                                                                                 |  |  |  | 23b. DATE 10/6/1983                                                                                                        |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY ONEV SHOLOM FARMID TORAT CONGREGATION CEMETERY                                                                                                                                                                                                                      |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.                                                                   |  |  |  |
| 24. FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C.                                                                                                                                                                                                                                            |  |  |  | 25. DATE REC'D BY REGISTRAR 10/11/83                                                                                       |  |  |  |





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

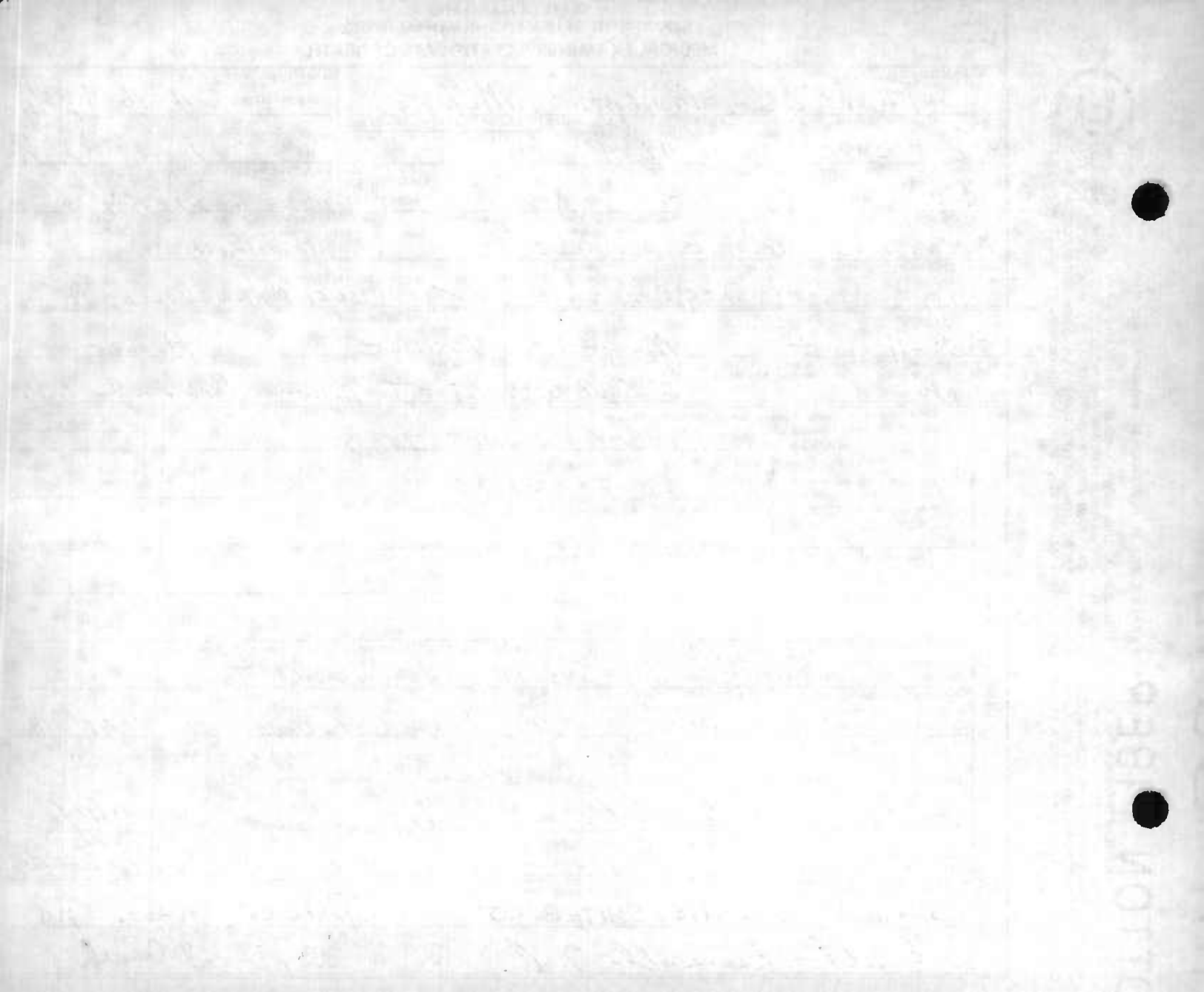
REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                       |                                                                                                                                          |                                                                                                                                                                                                                               |                                                                                                                                                            |                                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| 1- DECEASED NAME<br>(TYPE OR PRINT) <b>FRANCES MORGAN MENKE</b>                                                                                                                                                                                                                                                                                                                                                                                               |                       |                                                                                                                                          | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN <b>10 16 1983 340 AM</b> |                                                                                                                                                            |                                                                                  |
| 3 SEX<br><b>Fe</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4 RACE<br><b>CAUC</b> | 5 DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>12</b> YEAR <b>42</b>                                                                           | 6 AGE (IN YEARS)<br>LAST BIRTHDAY <b>41</b> YRS.                                                                                                                                                                              | IF UNDER 1 YR.<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>               | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WEST VA.</b>                                                                                                                                                                                                                                                                                                                                                                                                  |                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                                                                                             |                                                                                                                                                                                                                               | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                  |
| 10. CITY OR TOWN OF DEATH<br><b>BARNSVILLE</b>                                                                                                                                                                                                                                                                                                                                                                                                                |                       | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>18031 BARNSVILLE RD</b> |                                                                                                                                                                                                                               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOME MAKER</b>                                                                         |                                                                                  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |                       | 13b. COUNTY<br><b>MONTGOMERY</b>                                                                                                         |                                                                                                                                                                                                                               | 13c. CITY OR TOWN<br><b>BARNSVILLE</b>                                                                                                                     |                                                                                  |
| 14. FATHER'S NAME<br>FIRST <b>Russell</b> MIDDLE <b>H.</b> LAST <b>MORGAN</b>                                                                                                                                                                                                                                                                                                                                                                                 |                       | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>VERNICE</b> MIDDLE <b>HOUSER</b> LAST <b>HOUSER</b>                                                 |                                                                                                                                                                                                                               | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                               |                                                                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                            |                       | 16b. SOCIAL SECURITY NO.<br><b>235-68-0360</b>                                                                                           |                                                                                                                                                                                                                               | 17. INFORMANT<br><b>Peter T. Menke</b> ADDRESS <b>BARNSVILLE MD.</b>                                                                                       |                                                                                  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>GUNSHOT WOUND HEAD</b><br>9554<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>DEPRESSION</b><br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                       |                                                                                                                                          |                                                                                                                                                                                                                               |                                                                                                                                                            |                                                                                  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>_____                                                                                                                                                                                                                                                                                                                  |                       |                                                                                                                                          |                                                                                                                                                                                                                               |                                                                                                                                                            |                                                                                  |
| 19a. DATE OF OPERATION<br><b>—</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>—</b>                                                                            |                                                                                                                                                                                                                               | 20 AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                         |                                                                                  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                |                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>355 AM 10 16 1983</b>                                                              |                                                                                                                                                                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>SHOT HERSELF RT TEMPLE</b>                                             |                                                                                  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                    |                       | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>HOME</b>                                                               |                                                                                                                                                                                                                               | 21f. LOCATION<br>STREET <b>18031 BARNSVILLE RD</b> CITY OR TOWN <b>BARNSVILLE</b> COUNTY <b>MONT</b> STATE <b>MD</b>                                       |                                                                                  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>             |                       |                                                                                                                                          |                                                                                                                                                                                                                               |                                                                                                                                                            |                                                                                  |
| ACTUAL SIGNATURE<br><b>Francis C Mayle</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |                       | TITLE (SPECIFY)<br><b>DEPT</b>                                                                                                           |                                                                                                                                                                                                                               | DATE SIGNED<br><b>10/16/83</b>                                                                                                                             |                                                                                  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>FRANCIS C MAYLE</b>                                                                                                                                                                                                                                                                                                                                                                                                     |                       | ADDRESS <b>8200 Wisconsin Ave Bethesda MD</b>                                                                                            |                                                                                                                                                                                                                               |                                                                                                                                                            |                                                                                  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>                                                                                                                                                                                                                                                                                                                                                                                              |                       | 23b. DATE<br><b>10-16-1983</b>                                                                                                           |                                                                                                                                                                                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SMITHBURG</b>                                                                                                     |                                                                                  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>SMITHBURG</b>                                                                                                                                                                                                                                                                                                                                                                                                             |                       | COUNTY<br><b>WASH.</b>                                                                                                                   |                                                                                                                                                                                                                               | STATE<br><b>MD.</b>                                                                                                                                        |                                                                                  |
| 24 FUNERAL DIRECTOR<br>NAME <b>W. C. Helt</b> ADDRESS <b>Barneville Md.</b>                                                                                                                                                                                                                                                                                                                                                                                   |                       | 25a. DATE REC'D. BY REGISTRAR <b>OCT 21 1983</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>                                        |                                                                                                                                                                                                                               |                                                                                                                                                            |                                                                                  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                     |  |                                                                                                                                  |  | REG. NO.                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CONCETTA MESSINGER</b>                                                                                            |  |                                                                                                                                  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>10-4-83</b>                                                                                                          |  |                                                                                                                                                                                                                                                                                                                            |  |
| 3. SEX <b>FEMALE</b>                                                                                                                                     |  |                                                                                                                                  |  | 2b. HOUR <b>8<sup>50</sup> A M</b>                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                            |  |
| 4. RACE <b>WHITE</b>                                                                                                                                     |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>11-3-31</b>                                                                                   |  | 6. AGE (IN YEARS (LAST BIRTHDAY)) <b>51</b> YRS.                                                                                                         |  | 7. UNDER 1 YEAR MONTHS DAYS                                                                                                                                                                                                                                                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ITALY</b>                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.                                                                                                                                                                                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASH. AVENT. HOSP.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ACCOUNTANT</b>                                                                          |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>TAYROLL</b>                                                                                                                                                                                                                                                                           |  |
| 13a. STATE <b>MARYLAND</b>                                                                                                                               |  | 13b. COUNTY <b>MONTGOMERY</b>                                                                                                    |  | 13c. CITY OR TOWN <b>TAKOMA PARK</b>                                                                                                                     |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>ANTHONY STURBA</b>                                                                                                |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CAROLINE SPEENEY</b>                                                               |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>                                                                               |  | 17. SOCIAL SECURITY NO. <b>223-48-574</b>                                                                                                                                                                                                                                                                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>respiratory failure</b>      |  | 19. DATE OF OPERATION <b>10/7/83</b>                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>COPD</b>                                                                                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1749</b>                                               |  | DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cancer of breast</b>                                                                       |  | DUE TO, OR AS A CONSEQUENCE OF (c) <b>metastatic to bone, lung</b>                                                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>1749</b>             |  |                                                                                                                                  |  |                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)       |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9/7 1983</b>                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  | 22a. CERTIFY THAT (I) (this hospital) attended the deceased from <b>10/4/83</b> to <b>10/4/83</b> , that (I) (we) last saw the deceased alive on <b>10/4/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                              |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  | 22b. SIGNATURE <b>Maxim J. Meltz</b> DEGREE <b>MD</b>                                                                                                                                                                                                                                                                      |  |
| 22c. DATE SIGNED <b>10-4-83</b>                                                                                                                          |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARTIN D. WERTZ</b>                                                                     |  | 22e. ADDRESS <b>7676 New Hampshire; Langley Park MD</b>                                                                                                  |  | 22f. DATE SIGNED <b>10-4-83</b>                                                                                                                                                                                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>                                                                                                  |  | 23b. DATE <b>10/7/1983</b>                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY <b>MT CALVARY CEM.</b>                                                                                                |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>MONONGALIA, W. VIRGINIA</b>                                                                                                                                                                                                                                                     |  |
| 24. FUNERAL DIRECTOR NAME <b>ARTHUR L. LUTHER</b>                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 7 1983</b>                                                                                  |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Lander</b>                                                                                                         |  | 25c. DATE REC'D. BY REGISTRAR <b>OCT 7 1983</b>                                                                                                                                                                                                                                                                            |  |
| 26. FUNERAL HOME NAME <b>TAKOMA FUN &amp; HOME, INC</b>                                                                                                  |  | 26b. ADDRESS <b>N.W. WASH. T.C. 20012</b>                                                                                        |  | 26c. DATE REC'D. BY REGISTRAR <b>OCT 7 1983</b>                                                                                                          |  | 26d. REGISTRAR'S SIGNATURE <b>John J. Lander</b>                                                                                                                                                                                                                                                                           |  |

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No.

CONFIDENTIAL

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                                                                    |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Helene D. Michel                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 22, 1983                |                                                                                                                                                             |                                                                                                                                                      | 2b. HOUR<br>9:45a.m.                                                                 |                                                                    |                                                                                                                            |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br>Caucasian                                                                                                        |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 13, 1894                                                                                                         |                                                                                                                                                      | 6. AGE (IN YEARS AND BIRTHDAY)<br>89 YRS                                             |                                                                    | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States                                                                               |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                        |                                                                    |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Fernwood House |                                                                        |                                                                                                                                                             |                                                                                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Medical Doctor   |                                                                    | 12b. KIND OF BUSINESS OR INDUSTRY<br>University                                                                            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Maryland                                                                                                                                                                                                                                                          |  |                                                                                                                             | 13c. CITY OR TOWN<br>Montgomery Bethesda                               |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                      |                                                                                      | 13e. STREET ADDRESS<br>(20817)<br>9207 Wadsworth Drive             |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Louis Doetsch                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Joanna Pohl           |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                                                                    |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                      |  |                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-54-5015 |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br>Joan M. Main, same as #13                                                                                                |                                                                                      |                                                                    |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Respiratory failure -</u><br>4860<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                                                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u><br><u>7 days</u>                                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Carcinoma breast; Cerebral vascular accident</u>                                                                                                                                                                                      |  |                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                                                                    |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                        |  |                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                                                      |                                                                    |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                       |  |                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                                      |                                                                    |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August 29</u> , 19 <u>80</u> , to <u>22 Oct</u> , 19 <u>83</u> , that (we) last saw the deceased alive on <u>15 Oct</u> , 19 <u>83</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.                  |  |                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                                                                    |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>Horace W. Bernton</u><br>22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Horace W. Bernton, M.D.                                                                                                                                                                                                                                                                  |  |                                                                                                                             |                                                                        |                                                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                      | 22c. DATE SIGNED<br>Oct. 22, 1983                                  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                             | 23b. DATE<br>Oct 25, 1983                                              |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crem.                                                                                             |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Alexandria, Virginia |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814                                                                                                                                                                                                                                                                                 |  |                                                                                                                             |                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>OCT 25 1983                                                                                                         |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Church</u>                |                                                                                                                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 / 8 3

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|                                                                                                                   |                                                                                                                                  |                                                                                                                                                             |                                                                               |                              |                                                                                                 |
|-------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|------------------------------|-------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Florence M Miller                                     |                                                                                                                                  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 03 83                               |                              | 2b. HOUR<br>1 30 PM                                                                             |
| 3. SEX<br>Female                                                                                                  | 4. RACE<br>Caucasian                                                                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 - 3 02                                                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.                                    |                              | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, D.C.                                                     | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                 |                              |                                                                                                 |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring                                                                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |                              | 12b. KIND OF BUSINESS OR INDUSTRY<br>none                                                       |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland |                                                                                                                                  |                                                                                                                                                             | 13b. COUNTY<br>Montgomery                                                     | 13c. CITY OR TOWN<br>Wheaton | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank J. Metcalf                                                        |                                                                                                                                  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Virginia E. Claybough        |                              |                                                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                        |                                                                                                                                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>678-54-4717                                                                                      | 17. INFORMANT<br>ADDRESS<br>John Miller-son 3305 Floral St Wheaton, MD        |                              |                                                                                                 |

|                                                                                                                                                                                                                                                                                                                                                    |  |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br><u>4140</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Atherosclerotic coronary artery disease</u><br>(c) <u>10 yrs.</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Carcinoma of the breast

|                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                                            |                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                           |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                                                                            |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>year 1973</u> , 19 <u>10-3</u> , 19 <u>1983</u> , that (I) (we) lost saw the deceased alive on <u>9-30</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |                                                                        |                                                                                                                                            |                                                                                                                            |
| 22b. SIGNATURE<br><u>Eino Magi, M.D.</u>                                                                                                                                                                                                                                                                                                            | DEGREE                                                                 | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><u>10-4-83</u>                                                                                         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>EINO MAGI, M.D.</u>                                                                                                                                                                                                                                                                                     |                                                                        | 22e. ADDRESS<br><u>11120 New Hampshire Ave., Silver Spring, Md. 20904</u>                                                                  |                                                                                                                            |

|                                                        |                              |                                                    |                                                                   |
|--------------------------------------------------------|------------------------------|----------------------------------------------------|-------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation | 23b. DATE<br>October 5, 1983 | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Alexandria Virginia |
| 24. FUNERAL DIRECTOR<br>NAME<br>Francis J. Collins     |                              | 25a. DATE REC'D. BY REGISTRAR<br>OCT 13 1983       | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Conner</u>               |
| 500 University Blvd., W. Silver Spring, Md.            |                              |                                                    |                                                                   |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Handwritten text, possibly a date or time, including the word "THURSDAY" and "10:00". The text is written in a cursive, slanted style.

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R2/24, 22 by Medical Examiner Dr. F. Mayle  
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                   |  |                                                                                                  |                                                                |                                                                                                                                                                                                                                                                                                                      | REG. NO.                   |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Frances E. Miller</b>                                                                                                                                                                                                                                                                                                        |  |                                                                                                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 16, 1983</b> |                                                                                                                                                                                                                                                                                                                      | 2b. HOUR<br><b>7:56P M</b> |  |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                 |  | 4 RACE<br><b>Caucasian</b>                                                                       |                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 2, 1898</b>                                                                                                                                                                                                                                                            |                            |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b>                                                                                                                                                                                                                                                                                                                            |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                     |                                                                | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                                                                                                                                                                                                 |                            |  |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                             |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD</b>                              |                                                                | 10 CITY OR TOWN OF DEATH<br><b>Washington Grove</b>                                                                                                                                                                                                                                                                  |                            |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>101 Ridge Road</b>                                                                                                                                                                                                                                     |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Reviewer</b>              |                                                                | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>I.R.S.</b>                                                                                                                                                                                                                                                                   |                            |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY<br><b>Montgomery</b>                                                                 |                                                                | 13c. STREET ADDRESS<br><b>101 Ridge Road 20880</b>                                                                                                                                                                                                                                                                   |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John F. Ertter</b>                                                                                                                                                                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary E. Crane</b>                            |                                                                | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                    |                            |  |
| 16b. SOCIAL SECURITY NO.<br><b>216 44 4255</b>                                                                                                                                                                                                                                                                                                                         |  | 17. INFORMANT<br><b>Zip 20850 9209 Scott Drive</b><br><b>Frank Ertter brother Rockville, Md.</b> |                                                                | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br><b>3448</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pseudo bulbar palsy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary heart disease</b> |                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                 |                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                 |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                       |                                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                                       |                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                           |                                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                    |                            |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>Feb. 22</b> , 19 <b>82</b> , to <b>Oct. 16</b> , 19 <b>83</b> , that (1) (we) last saw the deceased alive on <b>Sept. 22</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death. |  |                                                                                                  |                                                                |                                                                                                                                                                                                                                                                                                                      |                            |  |
| 22b. SIGNATURE<br><b>Sidney J. Cohen</b>                                                                                                                                                                                                                                                                                                                               |  | 22c. DATE SIGNED<br><b>1983 Oct. 17,</b>                                                         |                                                                | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Sidney Cohen, M.D.</b>                                                                                                                                                                                                                                                   |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br><b>Oct. 19, 1983</b>                                                                |                                                                | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's Cemetery</b>                                                                                                                                                                                                                                                     |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rockville, Montgomery, Md.</b>                                                                                                                                                                                                                                                                                        |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey</b>                                        |                                                                | 25a. DATE RECEIVED BY REGISTRAR<br><b>OCT 24 1983</b>                                                                                                                                                                                                                                                                |                            |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                                                                                                                                                                                                                                                                                                    |  | 25c. ADDRESS<br><b>121 Congressional Lane Rockville, Md.</b>                                     |                                                                | 25d. DATE RECEIVED BY REGISTRAR<br><b>OCT 24 1983</b>                                                                                                                                                                                                                                                                |                            |  |

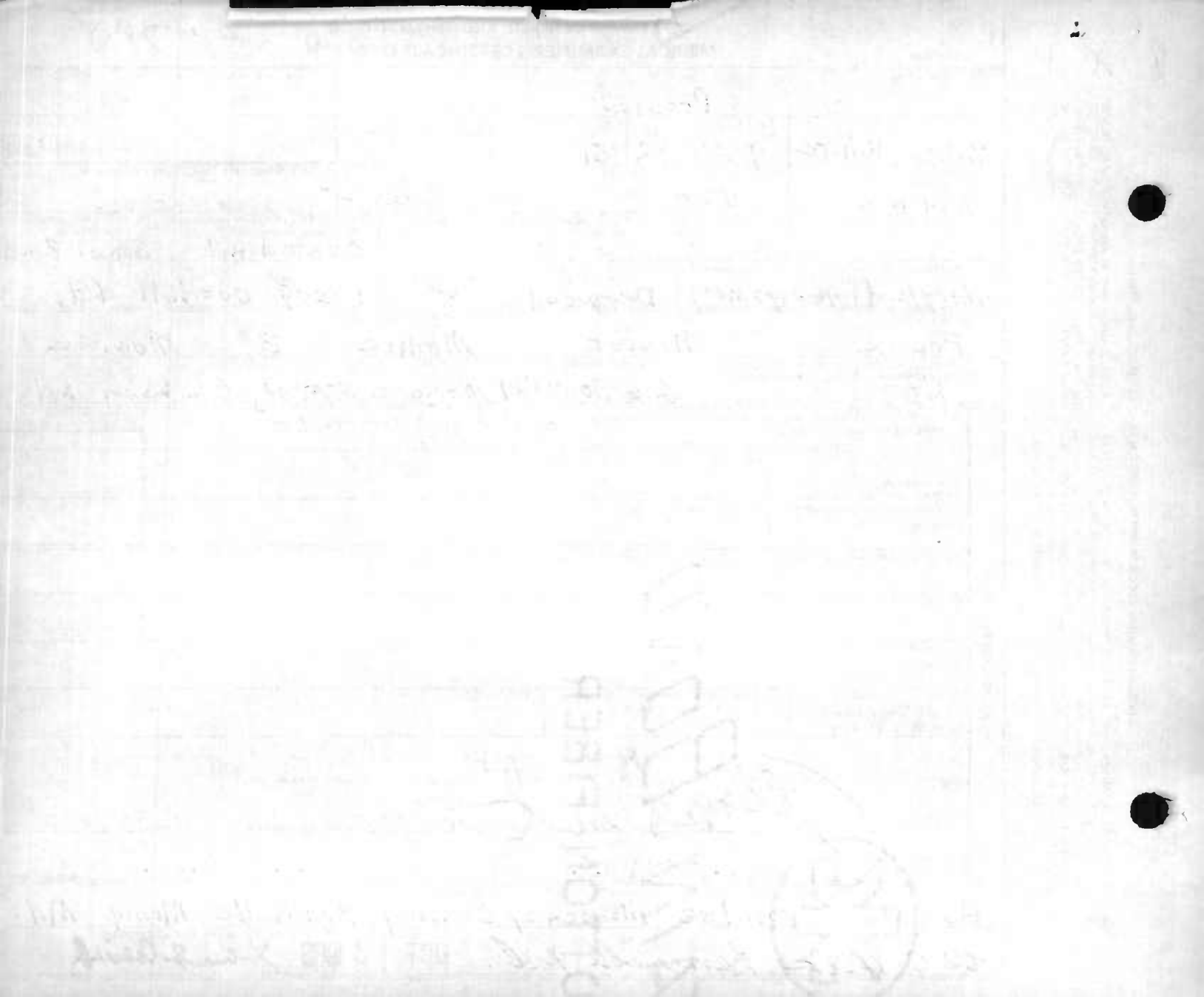


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4-82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                |  |                      |                                                                                                                                     |                                                             |                                                             |                                                                                                                                                          |                                                                                |                                                                          |                                                                                              | REG. NO. 21785                                                                      |  |                                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--|-----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                      |                                                                                                                                     |                                                             |                                                             |                                                                                                                                                          |                                                                                |                                                                          |                                                                                              |                                                                                     |  |                                               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FLOYD PRESTON MONROE</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                      |                                                                                                                                     |                                                             |                                                             |                                                                                                                                                          | 2a. DATE KNOWN OF DEATH <b>10 7 1983</b>                                       |                                                                          | 2b. HOUR <b>8:20P</b>                                                                        |                                                                                     |  |                                               |  |
| 3. SEX <b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE <b>White</b> |                                                                                                                                     | 5. DATE OF BIRTH <b>9 27 32</b>                             |                                                             | 6. AGE (IN YEARS) <b>51</b> YRS.                                                                                                                         |                                                                                | 7c. DATE PRONOUNCED DEAD <b>10 7 1983</b>                                |                                                                                              | 7d. HOUR <b>8:20P</b>                                                               |  |                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                             |                                                             |                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                |                                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>                           |                                                                                     |  |                                               |  |
| 10. CITY OR TOWN OF DEATH <b>Rockville</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Hospital</b> |                                                             |                                                             |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CUSTODIAN</b> |                                                                          |                                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY <b>School Band</b>                                |  |                                               |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                             |  |                      |                                                                                                                                     |                                                             |                                                             |                                                                                                                                                          |                                                                                |                                                                          |                                                                                              |                                                                                     |  |                                               |  |
| 13a. STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  |                      | 13b. COUNTY <b>Montgomery</b>                                                                                                       |                                                             |                                                             | 13c. CITY OR TOWN <b>Derwood</b>                                                                                                                         |                                                                                |                                                                          | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                     |  | 13e. STREET ADDRESS <b>17009 Overhill Rd.</b> |  |
| 14. FATHER'S NAME<br>FIRST <b>FRANK</b> MIDDLE LAST <b>MONROE</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                      |                                                                                                                                     |                                                             |                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MAMIE</b> MIDDLE <b>B.</b> LAST <b>MONROE</b>                                                                       |                                                                                |                                                                          |                                                                                              |                                                                                     |  |                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                                                                                                           |  |                      |                                                                                                                                     | 16b. SOCIAL SECURITY NO. <b>216-30-4529</b>                 |                                                             |                                                                                                                                                          |                                                                                | 17. INFORMANT <b>Margorie STATION, Clarksby Md.</b>                      |                                                                                              |                                                                                     |  |                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hemorrhagic pancreatitis</b><br><b>3030</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____                                                                                                                              |  |                      |                                                                                                                                     |                                                             |                                                             |                                                                                                                                                          |                                                                                |                                                                          |                                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                        |  |                                               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                    |  |                      |                                                                                                                                     |                                                             |                                                             |                                                                                                                                                          |                                                                                |                                                                          |                                                                                              |                                                                                     |  |                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                      |                                                                                                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                                                             |                                                                                                                                                          |                                                                                |                                                                          |                                                                                              | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                               |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    |  |                      |                                                                                                                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |                                                                                |                                                                          |                                                                                              |                                                                                     |  |                                               |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                        |  |                      |                                                                                                                                     | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                        |                                                                                |                                                                          |                                                                                              |                                                                                     |  |                                               |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                      |                                                                                                                                     |                                                             |                                                             |                                                                                                                                                          |                                                                                |                                                                          |                                                                                              |                                                                                     |  |                                               |  |
| ACTUAL SIGNATURE <b>Thomas D. Smith</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                      |                                                                                                                                     | TITLE (SPECIFY) <b>Deputy Chief</b>                         |                                                             |                                                                                                                                                          |                                                                                | DATE SIGNED <b>10/9/83</b>                                               |                                                                                              |                                                                                     |  |                                               |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                      |                                                                                                                                     | ADDRESS <b>111 Penn St. . Balto., MD.</b>                   |                                                             |                                                                                                                                                          |                                                                                |                                                                          |                                                                                              |                                                                                     |  |                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                      | 23b. DATE <b>10/11/83</b>                                                                                                           |                                                             | 23c. NAME OF CEMETERY OR CREMATORY <b>Monocacy Cemetery</b> |                                                                                                                                                          |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Beallsville Montg. Md.</b> |                                                                                              |                                                                                     |  |                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>W.C. Helt</b> ADDRESS <b>Barnesville Md.</b>                                                                                                                                                                                                                                                                                                                                                           |  |                      |                                                                                                                                     |                                                             |                                                             | 25a. DATE REC'D. BY REGISTRAR <b>OCT 13 1983</b>                                                                                                         |                                                                                | 25b. REGISTRAR'S SIGNATURE <b>John J. Canineh</b>                        |                                                                                              |                                                                                     |  |                                               |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                      |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                                                                            |                                                      |                                                                                                                            |                                                        | REG. NO.                                                      |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|---------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Georgianna W Morecraft</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                               |                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10-18-83</b>                                             |                                                                                                                                            |                                                      | 2b. HOUR<br><b>7 PM</b>                                                                                                    |                                                        |                                                               |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br><b>Caucasian</b>                                                                                                                   |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 18, 1904</b>                                                                                                   |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS                                                                                           |                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                             |                                                        | IF UNDER 24 HRS<br>HOURS MIN.                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                    |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                                                              |                                                      |                                                                                                                            |                                                        |                                                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Kensington</b>                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Circle Manor Nursing Home</b> |                                                                        |                                                                                                                                                             |                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Hospital Worker</b>                                                 |                                                      |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>D.C. Gov't</b> |                                                               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Kensington</b>                                                                                                                                                                                   |  |                                                                                                                                               |                                                                        |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                            | 13e. STREET ADDRESS<br><b>10231 Carroll Pl 20895</b> |                                                                                                                            |                                                        |                                                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George nmnn Wilson</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                               |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth nmnn Wolford</b>                                                                              |                                                                                                 |                                                                                                                                            |                                                      |                                                                                                                            |                                                        |                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-14-5869</b>                                                                 |                                                                        | 17. INFORMANT ADDRESS<br><b>Mrs Mary Schaaf 3110 Kingtree St Wheaton, Md. 20902</b>                                                                         |                                                                                                 |                                                                                                                                            |                                                      |                                                                                                                            |                                                        |                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Colon</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                                                                            |                                                      |                                                                                                                            |                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 mos.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.<br><b>Parkinsonism</b>                                                                                                                                                                                                                |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                                                                            |                                                      |                                                                                                                            |                                                        |                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |                                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                        |                                                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                  |  |                                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                                      |                                                                                                                            |                                                        |                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                              |  |                                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                      |                                                                                                                            |                                                        |                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 19 73</b> to <b>10/18</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>10/18</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                      |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                                                                            |                                                      |                                                                                                                            |                                                        |                                                               |  |
| 22b. SIGNATURE<br><b>R. T. Benack</b> DEGREE                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                                                 | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                      |                                                                                                                            | 22c. DATE SIGNED<br><b>10/18/83</b>                    |                                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. T. Benack MD</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                                                 | 22e. ADDRESS<br><b>4115 Colie DR, Wheaton, Md 20906</b>                                                                                    |                                                      |                                                                                                                            |                                                        |                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                               | 23b. DATE<br><b>Oct 21, 1983</b>                                       |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Peters &amp; Paul</b>                              |                                                                                                                                            |                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cumberland, Allegany, Md</b>                                              |                                                        |                                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>W. W. Chambers Co, Inc; 8655 Georgia Ave Silver Spring, Md. 20910</b>                                                                                                                                                                                                                                                                     |  |                                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 24 1983</b>                                                                                        |                                                      |                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>    |                                                               |  |

BP





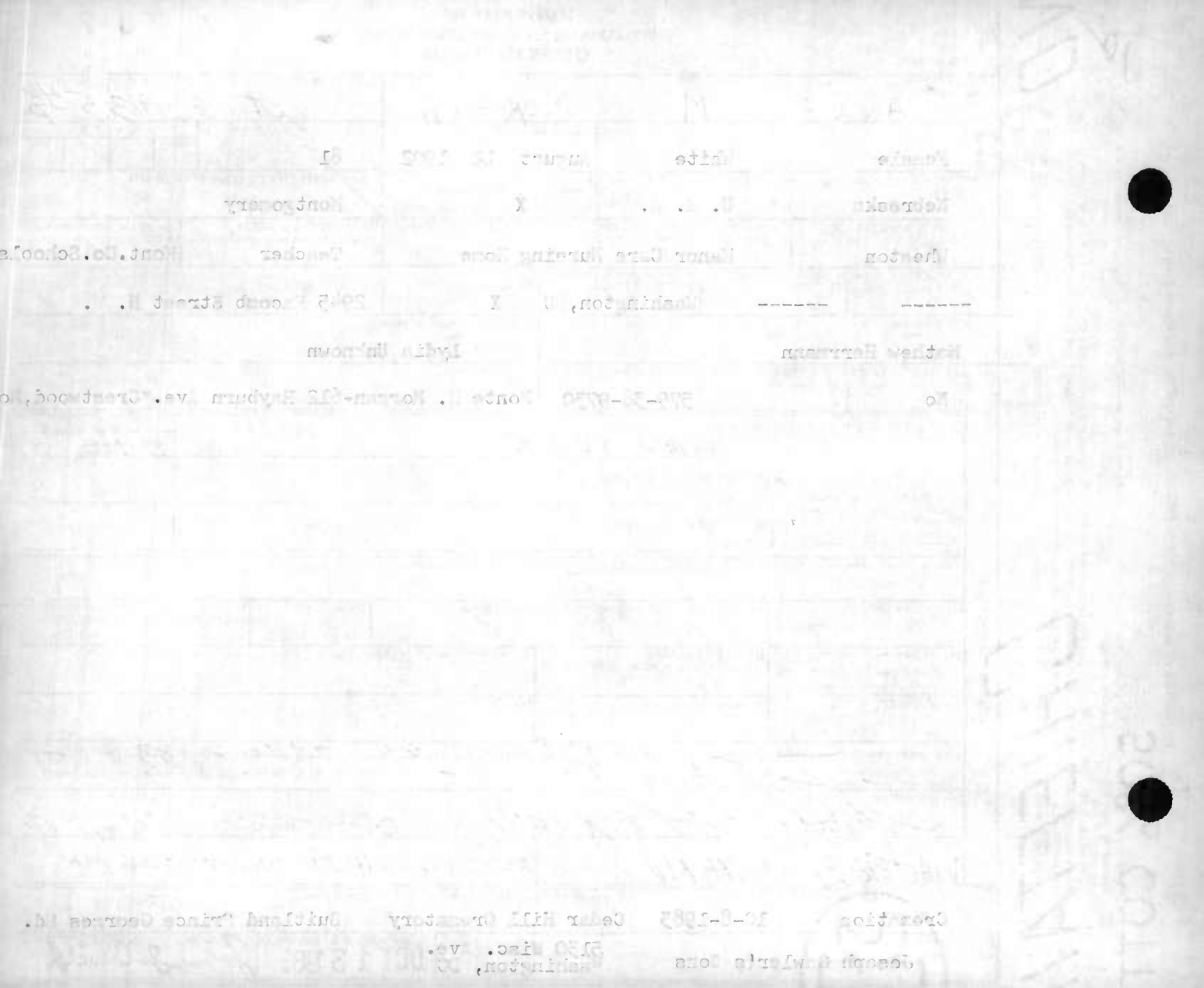
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and attached.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                      |  | REG. NO.                                                                                                                                                    |  |                                                                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                      |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR                                                                                                                   |  |                                                                                                                         |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>ANNA M MORGAN                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                      |  | OCT 6 1983 5:40 PM                                                                                                                                          |  |                                                                                                                         |  |
| 2. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br>White                                                                                                                     |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>August 12 1902                                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.                                                                                 |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Nebraska                                                                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                                                                                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD                                                                   |  |
| 10. CITY OR TOWN OF DEATH<br>Wheaton                                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Manor Care Nursing Home |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Teacher                                                                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Mont.Co.Schools                                                                    |  |
| 13a. STATE<br>-----                                                                                                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY<br>-----                                                                                                                 |  | 13c. CITY OR TOWN<br>Washington, DC                                                                                                                         |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Mathew Herrmann                                                                                                                                                                                                                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lydia Unknown                                                                          |  | 13e. STREET ADDRESS<br>2945 Macomb Street N. W. 99999                                                                                                       |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) No                                                                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.<br>579-38-9730                                                                                              |  | 17. INFORMANT ADDRESS<br>Monte H. Morgan-612 Rayburn Ave.*Crestwood, Mo                                                                                     |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) BRAIN TUMOR 2396<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>8 MO |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                                                        |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                                                                              |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from February 19 83, to October 6, 19 83, that (I) (we) last saw the deceased alive on Oct 1 19 83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                  |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 22b. SIGNATURE<br>Walter E. Gooch MD                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                      |  | DEGREE<br>MD                                                                                                                                                |  | 22c. DATE SIGNED<br>Oct 6, 1983                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WALTER E. GOOCH MD                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                      |  | 22e. ADDRESS<br>2309 SHOREFIELD RD SILVER SPRING MD                                                                                                         |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br>10-8-1983                                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Crematory                                                                                                  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Suitland Prince Georges Md.                                                  |  |
| 24. FUNERAL DIRECTOR NAME<br>Joseph Gawler(s) Sons                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                      |  | ADDRESS<br>5130 Wisc. Ave Washington, DC                                                                                                                    |  | 25. DATE REC'D. BY REGISTRAR<br>OCT 13 1983                                                                             |  |
| 25. REGISTRAR'S SIGNATURE<br>John J. Gawler                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                         |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| FOR<br>1 - STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                  |  | 2a. DATE OF DEATH                                                                                                               |  | MONTH DAY YEAR                                                                                                                                              |  | 2b. HOUR                                                                                                                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                            |  | FIRST MIDDLE LAST                                                                                                               |  | 10/31/83                                                                                                                                                    |  | 11:30 P.M.                                                                                                                 |  |
| 3. SEX<br>F FEMALE                                                                                                                                                                                                                                                                                             |  | 4. RACE<br>WHITE                                                                                                                |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 12 1881                                                                                                          |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>102 YRS.                                                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>ONTARIO, CANADA                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                                                              |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>5622 SOUTHWICK ST. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                                                                              |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY<br>MONT.                                                                                                            |  | 13c. CITY OR TOWN<br>BETHESDA                                                                                                                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>THOMAS                                                                                                                                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>PRISCILLA EYES WATSON                                                          |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                  |  | 16b. SOCIAL SECURITY NO.<br>N/A                                                                                            |  |
| 17. INFORMANT (Daughter)                                                                                                                                                                                                                                                                                       |  | ADDRESS<br>5622 Southwick                                                                                                       |  | 18. BEATRICE STEYSKAL, BETHESDA, MD                                                                                                                         |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) LUNG CANCER<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)                                                                               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>~ 2 YEARS                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br>ATHEROSCLEROSIS                                                                                                                                                             |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                          |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/9 19 82 to 10/31 19 83, that (we) last saw the deceased alive on 10/24 19 83, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, (I) (did) (did not) view the body after death.) |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>Alfred Muller M.D.                                                                                                                                                                                                                                                                           |  | DEGREE<br>M.D.                                                                                                                  |  | 22c. DATE SIGNED<br>10/31/83                                                                                                                                |  |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ALFRED MULLER                                                                                                                                                                                                                                                         |  | 22e. ADDRESS<br>3301 New Mexico Ave, NW Washington, D.C. 20016                                                                  |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                         |  | 23b. DATE<br>Nov. 5, 1983                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Sepulchre                                                                                                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Southfield Oakland County Michigan                                           |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert A. Pumphrey Funeral Homes, P.A., 7557 Wisconsin Ave., Bethesda, Maryland                                                                                                                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 4 1983                                                                                     |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                                  |  |                                                                                                                            |  |

MEDICAL CERTIFICATION





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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                           |  |         |  |                                                                                                            |  |                                                                |  |                                                                                                                                                             |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |                                                                                     |  |                                                 |  |                                                                                                 |  |                     |  | REG. NO. |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------|--|------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|-------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|---------------------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                    |  |         |  |                                                                                                            |  |                                                                |  |                                                                                                                                                             |  | 26. DATE KNOWN<br>OF DEATH                                                         |  |                                                                                     |  |                                                 |  |                                                                                                 |  |                     |  | 26. HOUR |  |
| Ritz Ann Morgan                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |         |  |                                                                                                            |  |                                                                |  |                                                                                                                                                             |  | Oct. 4 1983                                                                        |  |                                                                                     |  |                                                 |  |                                                                                                 |  |                     |  | 4:50 PM  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE |  | 5. DATE OF BIRTH<br>(MONTH DAY YEAR)                                                                       |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)                           |  | 7. IF UNDER 1 YR.<br>(MONTHS DAYS HOURS MIN)                                                                                                                |  | 7c. DATE<br>PRONOUNCED<br>DEAD                                                     |  | 26. HOUR                                                                            |  | 26. MIN                                         |  |                                                                                                 |  |                     |  |          |  |
| F                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | W       |  | April 30 1951                                                                                              |  | 51 YRS.                                                        |  |                                                                                                                                                             |  | Oct. 4 1983                                                                        |  | 4:50 PM                                                                             |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                           |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                               |  |                                                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| 10a. 10a.                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |         |  | USA.                                                                                                       |  |                                                                |  |                                                                                                                                                             |  |                                                                                    |  | Montgomery MD                                                                       |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                              |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                     |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| Tak Park Wash                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |         |  | Advent Hosp Board Member Montgomery MD                                                                     |  |                                                                |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                     |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| 12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                        |  |         |  |                                                                                                            |  |                                                                |  |                                                                                                                                                             |  |                                                                                    |  | 12b. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                    |  |                                                 |  | 12c. KIND OF BUSINESS<br>OR INDUSTRY                                                            |  |                     |  |          |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |         |  |                                                                                                            |  |                                                                |  |                                                                                                                                                             |  |                                                                                    |  | 13b. COUNTY                                                                         |  | 13c. CITY OR TOWN                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS |  |          |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |         |  |                                                                                                            |  |                                                                |  |                                                                                                                                                             |  |                                                                                    |  | Mont                                                                                |  | Silver Spring                                   |  | YES                                                                                             |  | 9222 Winwood St.    |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                 |  |         |  |                                                                                                            |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                  |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                     |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| Leo Michael Corran                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |         |  |                                                                                                            |  | Emily Henrik                                                   |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                     |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                  |  |         |  |                                                                                                            |  | 16b. SOCIAL SECURITY NO.                                       |  |                                                                                                                                                             |  |                                                                                    |  | 17. INFORMANT ADDRESS                                                               |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| No                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |         |  |                                                                                                            |  | 483-344514                                                     |  |                                                                                                                                                             |  |                                                                                    |  | SCOTT D. Anderson Legal Rep.                                                        |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                |  |         |  |                                                                                                            |  |                                                                |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                     |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |                                                                                                 |  |                     |  |          |  |
| IMMEDIATE CAUSE (a) Asphyxia                                                                                                                                                                                                                                                                                                                                                                                                                           |  |         |  |                                                                                                            |  |                                                                |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                     |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| 9530 DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                                    |  |         |  |                                                                                                            |  |                                                                |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                     |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.                                                                                                                                                                                                                                                                                                                                                          |  |         |  |                                                                                                            |  |                                                                |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                     |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| (b) Hanging                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |         |  |                                                                                                            |  |                                                                |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                     |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                                         |  |         |  |                                                                                                            |  |                                                                |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                     |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| (c)                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |         |  |                                                                                                            |  |                                                                |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                     |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.                                                                                                                                                                                                                                                                                                                        |  |         |  |                                                                                                            |  |                                                                |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                     |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| None                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |         |  |                                                                                                            |  |                                                                |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                     |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |         |  |                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?              |  |                                                                                                                                                             |  |                                                                                    |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| None                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |         |  |                                                                                                            |  |                                                                |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                     |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                   |  |         |  |                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>10:04 1983  |  |                                                                                                                                                             |  |                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)       |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |         |  |                                                                                                            |  |                                                                |  |                                                                                                                                                             |  |                                                                                    |  | Hung Self                                                                           |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                   |  |         |  |                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.) |  |                                                                                                                                                             |  |                                                                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |         |  |                                                                                                            |  | Hospital                                                       |  |                                                                                                                                                             |  |                                                                                    |  | Czura 11 Ave Tak Park Mont Md                                                       |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |         |  |                                                                                                            |  |                                                                |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                     |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |         |  |                                                                                                            |  | TITLE (SPECIFY)                                                |  |                                                                                                                                                             |  |                                                                                    |  | DATE SIGNED                                                                         |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| [Signature]                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |         |  |                                                                                                            |  | M.D. Days                                                      |  |                                                                                                                                                             |  |                                                                                    |  | Oct 4 1983                                                                          |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                     |  |         |  |                                                                                                            |  | ADDRESS                                                        |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                     |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                           |  |         |  |                                                                                                            |  | 23b. DATE                                                      |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  |                                                                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                          |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| Cremation                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |         |  |                                                                                                            |  | 10-6-83                                                        |  | Cedar Hill Crematory                                                                                                                                        |  |                                                                                    |  | Silver Spring Md.                                                                   |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                                                                                           |  |         |  |                                                                                                            |  | 25. DATE REC'D. BY REGISTRAR                                   |  |                                                                                                                                                             |  |                                                                                    |  | 26. REGISTRAR'S SIGNATURE                                                           |  |                                                 |  |                                                                                                 |  |                     |  |          |  |
| WW Chambers Co.                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |         |  |                                                                                                            |  | OCT 10 1983                                                    |  |                                                                                                                                                             |  |                                                                                    |  | John J. Chambers                                                                    |  |                                                 |  |                                                                                                 |  |                     |  |          |  |



*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|                                                                                                                                                                               |  |                                                                                                                                         |                                                                   |                                                                                                                                                             |  |                                                                                        |  |                                                  |                                                        |                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------|--|--------------------------------------------------|--------------------------------------------------------|-------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Daniel J Moriarty</b>                                                                                                                  |  |                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>19</b> YEAR <b>83</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>4</b> P.M.                                                              |  |                                                  |                                                        |                                                 |  |
| 3. SEX<br><b>male</b>                                                                                                                                                         |  | 4. RACE<br><b>white</b>                                                                                                                 |                                                                   | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>3</b> YEAR <b>51</b>                                                                                              |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>32</b> YRS.                                      |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |                                                        | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN. <b>0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, - DC</b>                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                              |                                                                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                          |  |                                                  |                                                        |                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring md</b>                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |                                                                   |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Electrician</b> |  |                                                  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Local # 26</b> |                                                 |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>md</b> 13b. COUNTY <b>PG</b> 13c. CITY OR TOWN <b>Bethville</b> |  |                                                                                                                                         |                                                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13e. STREET ADDRESS<br><b>4803 Naples Ave. 20705</b>                                   |  |                                                  |                                                        |                                                 |  |
| 14. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b>Joseph</b> LAST <b>Moriarty</b>                                                                                              |  |                                                                                                                                         |                                                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Nancy</b> MIDDLE <b>J.</b> LAST <b>Alexander</b>                                                                       |  |                                                                                        |  |                                                  |                                                        |                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>N/A</b>                                                                                               |  |                                                                                                                                         |                                                                   | 16b. (IF YES, GIVE WAR OR DATES)<br><b>N/A</b>                                                                                                              |  | 17. INFORMANT<br>ADDRESS<br><b>Joyce A. Moriarty-wife- (same as 13e)</b>               |  |                                                  |                                                        |                                                 |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

2050 IMMEDIATE CAUSE (a) **Respiratory Failure**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) **Acute myelogenous Leukemia**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
**12**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**Sepsis, Hepatic Insufficiency**

|                                                                                                                                                                                                                                                                                                                                                              |  |                                                                        |  |                                                                                      |  |                                                                                                                                       |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |                                                                                                                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/20</b> 19 <b>83</b> to <b>10/19</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>10/19</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                      |  |                                                                                                                                       |  |
| 22b. SIGNATURE<br><b>Peter B. Sherer</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                        |  | DEGREE<br><b>MD</b>                                                                  |  | 22c. DATE SIGNED<br><b>10/19/83</b>                                                                                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Peter B. Sherer MD</b>                                                                                                                                                                                                                                                                                           |  |                                                                        |  | 22e. ADDRESS<br><b>3947 Ferrara A. Wheaton, md 20906</b>                             |  |                                                                                                                                       |  |

|                                                                   |  |                                   |  |                                                             |  |                                                                                |  |
|-------------------------------------------------------------------|--|-----------------------------------|--|-------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>     |  | 23b. DATE<br><b>Oct. 22, 1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood Pr. Georges Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hines/Rinaldi Funeral Home</b> |  |                                   |  | ADDRESS<br><b>11800 N.H. Ave., Silver Spring, Md. 20904</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 21 1983</b>                            |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John A. Gried</b>                |  |                                   |  |                                                             |  |                                                                                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the medical examiner's office death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1100 N.E. Ave.,  
 Dec. 23, 1903, Fort Lincoln  
 Hentzwood T. George, M.D.  
 Hentzwood T. George, M.D.  
 Hentzwood T. George, M.D.



NOTION

1100 N.E. Ave.  
 Dec. 23, 1903, Fort Lincoln

Joseph A. Hentzwood (same as 1100)

John Joseph Hentzwood

1100 N.E. Ave.

Holy Cross Hospital

Hentzwood T. George, M.D.

BH



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           |  | REG. NO.                                                                                                                                                               |  |                                                                                                                                    |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|
| FOR Item 18b film 585<br>1- STATE 11-21-83 cn<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                           |  | 27792                                                                                                                                                                  |  |                                                                                                                                    |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>HELEN BESSIE MORROW</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                           |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>october 17, 1983</b>                                                                                                            |  | 2b. HOUR P M<br><b>3:55 P M</b>                                                                                                    |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><b>WHITE</b>                                                                                                                   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>JUNE 25, 1933</b>                                                                                                                |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br><b>50 YRS.</b>                                                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY COUNTY MD.</b>                                                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE CLINICAL CENTER, NIH</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                                                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>                                                                                     |  |
| 13a. STATE<br><b>North Carolina</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY<br><b>13b. CITY OR TOWN</b><br><b>Charlotte</b>                                                                               |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                           |  | 13e. STREET ADDRESS<br><b>425 Oakdale Road</b>                                                                                     |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Robert Page Gaddy</b>                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Elizabeth McCray</b>                                                                                                  |  |                                                                                                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no --</b>                                                                                                                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br><b>245-44-2507</b>                                                                                            |  | 17. INFORMANT ADDRESS<br><b>MR. EDWARD MORROW (HUSBAND) same as above</b>                                                                                              |  |                                                                                                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple pulmonary emboli, bilateral</b><br><b>7561</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Pt. Congenital arteriovenous</b><br>(b) <b>Large right thoracic paraspinal arterio-venous malformation in the paraspinal</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Muscles</b><br>(c) <b>Muscles</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Hours</b> |  |                                                                                                                                           |  |                                                                                                                                                                        |  |                                                                                                                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                           |  |                                                                                                                                                                        |  |                                                                                                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                         |  |                                                                                                                                    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                       |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                         |  |                                                                                                                                    |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 19, 1983</b> to <b>October 17, 1983</b> , that I (we) last saw the deceased on <b>September 19, 1983</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.                                                                                                                      |  |                                                                                                                                           |  |                                                                                                                                                                        |  |                                                                                                                                    |  |
| 22b. SIGNATURE <b>S Papazoglou</b> DEGREE <b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                           |  | 22c. DATE SIGNED<br><b>Oct. 18, 1983</b>                                                                                                                               |  |                                                                                                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Savvas Papazoglou, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                           |  | 22e. ADDRESS<br><b>NATIONAL INSTITUTES OF HEALTH<br/>CLINICAL CENTER, BETHESDA, MD. 20205</b>                                                                          |  |                                                                                                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br><b>10-21-83</b>                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Forest Lawn Cemetery</b>                                                                                                      |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Charlotte, N.C.</b>                                                                  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Marshall's Funeral Home</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                           |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 21 1983</b>                                                                                                                    |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                                                                |  |
| 4217 9th St. NW, Washington, D.C.                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                           |  |                                                                                                                                                                        |  |                                                                                                                                    |  |



20% DOLBY

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10-21-73  
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10-21-73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                               |  |                                                                                                                                      |                                                     |                                                                                                                                                             |  |                                                                                      |  |
|---------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Vendela M. Moss</i>    |  |                                                                                                                                      | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>10-14-83</i> |                                                                                                                                                             |  | 2b. HOUR<br><i>9:30</i> P.M.                                                         |  |
| 3. SEX<br><i>Female</i>                                       |  | 4. RACE<br><i>White</i>                                                                                                              |                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>April 18 1901</i>                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>82</i> YRS.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Illinois</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                           |                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.                        |  |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Holy Cross Hosp.</i> |                                                     |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Homemaker</i> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Own Home</i>          |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>        |                                                     | 13b. COUNTY<br><i>Montgomery</i>                                                                                                                            |  | 13c. CITY OR TOWN<br><i>Silver Spring</i>                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Martin Olson</i> |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Anna Marie Peterson</i>                                                          |                                                     | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>                                                |  |                                                                                      |  |
| 17a. SOCIAL SECURITY NO.<br><i>325-20-8506</i>                |  | 17. INFORMANT<br>NAME ADDRESS<br><i>Mrs. Barbara Beard 10814 Margate Rd.<br/>Silver Spring, Md.</i>                                  |                                                     |                                                                                                                                                             |  |                                                                                      |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) *5860 Congestive heart failure*

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) *Arteriosclerotic cardiovascular disease*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Renal failure*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH*1 week**10 yrs.**10 yrs*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

|                                                                                                                                                                                                                                                                                                                                             |  |                                                                       |  |                                                                                |  |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION<br><i>9/9</i>                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>January 1983</i> , to <i>Oct 14 1983</i> , that (I) (we) last saw the deceased alive on <i>Oct 14 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                       |  |                                                                                |  |                                                                                                                            |  |

|                                                                            |  |                                                                                                                                 |  |                  |  |
|----------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|------------------|--|
| 21g. SIGNATURE<br><i>Raymond Bradshaw, MD</i>                              |  | DEGREE                                                                                                                          |  | 22c. DATE SIGNED |  |
| 21h. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Raymond Bradshaw, Jr. M.D.</i> |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 1                |  |
| 22a. ADDRESS<br><i>345 University Blvd. W.<br/>Silver Spring, Md.</i>      |  |                                                                                                                                 |  |                  |  |

|                                                                                           |  |                                   |  |                                                                   |  |                                                                        |  |
|-------------------------------------------------------------------------------------------|--|-----------------------------------|--|-------------------------------------------------------------------|--|------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Cremation</i>                             |  | 23b. DATE<br><i>Oct. 17, 1983</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill Crematory</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Suitland P.G. Md.</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>W. W. Chambers Co. 8655 Ga. Ave. Silver Spring Md.</i> |  |                                   |  | 25. DATE REC'D. BY REGISTRAR<br><i>OCT 19 1983</i>                |  |                                                                        |  |
|                                                                                           |  |                                   |  | 26. REGISTRAR'S SIGNATURE<br><i>John J. Conner</i>                |  |                                                                        |  |



COLORED  
PAPER





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                   |  |                                                                                                                             |  |                                                                                                                                                             |  |                                                                               |  |                                                                  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                            |  | 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                         |  | FIRST MIDDLE LAST<br>DESSIE LEE MYERS                                                                                                                       |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCTOBER 19 1983                        |  | 2b. HOUR<br>2:04 P.M.                                            |  |
| 3. SEX<br>FEMALE                                                                                                                                                                  |  | 4. RACE<br>NEGROE                                                                                                           |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAY 31 1950                                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>33 YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>SOUTH CAROLINA                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>UNITED STATES                                                                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                        |  |                                                                  |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NAVAL HOSPITAL |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE |  | 12b. KIND OF BUSINESS OR INDUSTRY                                |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>SOUTH CAROLINA DORCHESTER SUMMERVILLE |  |                                                                                                                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  | 13e. STREET ADDRESS<br>175 SMITH ST 99999                                     |  |                                                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CHARLES HENRY BOWMAN                                                                                                                    |  |                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ODESSA LEE BOWMAN                                                                                          |  |                                                                               |  |                                                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                                            |  | 16b. SOCIAL SECURITY NO.<br>254-96-8474                                                                                     |  | 17. INFORMANT<br>ADDRESS<br>HENRY LEE MYERS 175 SMITH ST SUMMERVILLE SOUTH CAROLINA 95873                                                                   |  |                                                                               |  |                                                                  |  |

|                                                                                                                                                                                                                                                                                                       |  |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>2873 IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR COLLAPSE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>THROMBIC THROMBOCYTOPENIC PURPURA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

|                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                             |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>16 OCTOBER</u> 19 <u>83</u> , to <u>19 OCTOBER</u> 19 <u>83</u> , that (I) (we) lost<br>saw the deceased alive on <u>19 OCTOBER</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>R. L. Sollock                                                                                                                                                                                                                                                                                                                                                      |  | DEGREE                                                                 |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>20 OCT 83                                                                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. L. SOLLOCK                                                                                                                                                                                                                                                                                                                               |  | LCDR MC USN                                                            |  | 22e. ADDRESS<br>NAVAL HOSPITAL, NAVAL MEDICAL<br>COMMAND, NATIONAL CAPITAL REGION, BETHESDA MD 20814                                       |  |                                                                                                                            |  |

|                                                                                  |  |                       |  |                                                        |  |                                                                         |  |
|----------------------------------------------------------------------------------|--|-----------------------|--|--------------------------------------------------------|--|-------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                           |  | 23b. DATE<br>10-24-83 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Schuler Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Ridgeville, S.C. MD 20814 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert G. Mason funeral Home 1661 Good Hope Rd., |  |                       |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 27 1983           |  | 25b. REGISTRAR'S SIGNATURE<br>R. L. Sollock                             |  |

NOTES  
DATE: 10/10/1964  
BY: [illegible]

[Faint, mostly illegible handwritten notes and a large sketch of a rectangular area with internal lines, possibly a map or diagram.]

10/10/1964

10/10/1964

10/10/1964

10/10/1964

10/10/1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                          |  |  |  | REG. NO.                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  | 2a. DATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>Carrie Newhall Neal                                                                                                                                                                                                                                                                                                                                                                     |  |  |  | 2b. MONTH DAY YEAR<br>10 15 83                                                                                                                                                                                                                                                                                                                                                                   |  |  |  |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  | 2b. HOUR<br>4:35 P M                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |
| 4 RACE<br>Caucasian                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>95 YRS.                                                                                                                                                                                                                                                                                                                                                        |  |  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br>11 7 1887                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  | 8. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                                                                                                                                                                                                                                                                                                    |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Mass.                                                                                                                                                                                                                                                                                                                                                                            |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                                                                                                                                                                                                                                                                                                                                    |  |  |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                                                                                                                                                                                                                                                                                                                       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home                                                                                                                                                                                                                                                                                                                                                        |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Carriage Hill-Bethesda Cedar Lane 5215                                                                                                                                                                                                                                                                              |  |  |  | 13a. STREET ADDRESS<br>5117 Lawton Drive 20816                                                                                                                                                                                                                                                                                                                                                   |  |  |  |
| 12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>12a. STATE 12b. COUNTY<br>Maryland Montgomery                                                                                                                                                                                                                                                                                  |  |  |  | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                             |  |  |  |
| 13. CITY OR TOWN<br>Bethesda                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br>Charles Newhall                                                                                                                                                                                                                                                                                                                                           |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Charles Newhall                                                                                                                                                                                                                                                                                                                                                                        |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Nellie McNabb-Wright                                                                                                                                                                                                                                                                                                                               |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                                                                                                                                           |  |  |  | 16b. SOCIAL SECURITY NO.<br>550-18-7274 D                                                                                                                                                                                                                                                                                                                                                        |  |  |  |
| 17. INFORMANT ADDRESS<br>Barbara Chiosey Neal Finger, Beth., Md.                                                                                                                                                                                                                                                                                                                                                              |  |  |  | 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio</u><br><u>4292</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Vascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>                                                                                                                                                                                                                                                                                      |  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                                                 |  |  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                          |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                            |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                                                                                                                                                                                                                                          |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)                                                                                                                                                                                                                                                                                                                                               |  |  |  | 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                                                                                                           |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                                                                   |  |  |  |
| 22a. I certify that (I) ( <u>the hospital</u> ) attended the deceased from <u>Oct 10</u> , 19 <u>83</u> , to <u>Oct 15</u> , 19 <u>83</u> , that (I) ( <u>was</u> ) lost saw the deceased alive on <u>Oct 10</u> , 19 <u>83</u> , and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) ( <u>did</u> ) ( <u>do not</u> ) view the body after death. |  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |
| 22b. SIGNATURE<br><u>Dr. W. H. E. DeLaughter M.D.</u>                                                                                                                                                                                                                                                                                                                                                                         |  |  |  | 22c. DATE SIGNED<br>10-15-83                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Dr. W. H. E. DeLaughter M.D.</u>                                                                                                                                                                                                                                                                                                                                                  |  |  |  | 22e. ADDRESS<br><u>6318 Democracy Blvd Bethesda Md 20814</u>                                                                                                                                                                                                                                                                                                                                     |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                                                                        |  |  |  | 23b. DATE<br>10/17/1983                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Crematory                                                                                                                                                                                                                                                                                                                                                                    |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Suitland Maryland.                                                                                                                                                                                                                                                                                                                                    |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>Joseph Gawler's Sons Inc.</u><br>ADDRESS <u>5130 Wisc. Ave., N.W. Wash., D.C.</u>                                                                                                                                                                                                                                                                                                             |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 19 1983                                                                                                                                                                                                                                                                                                                                                     |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>John J. Conner</u>                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |

BP



Joseph Gendler's Sons Inc.  
1000 1st Ave. N.E.  
Atlanta, Ga. 30309

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

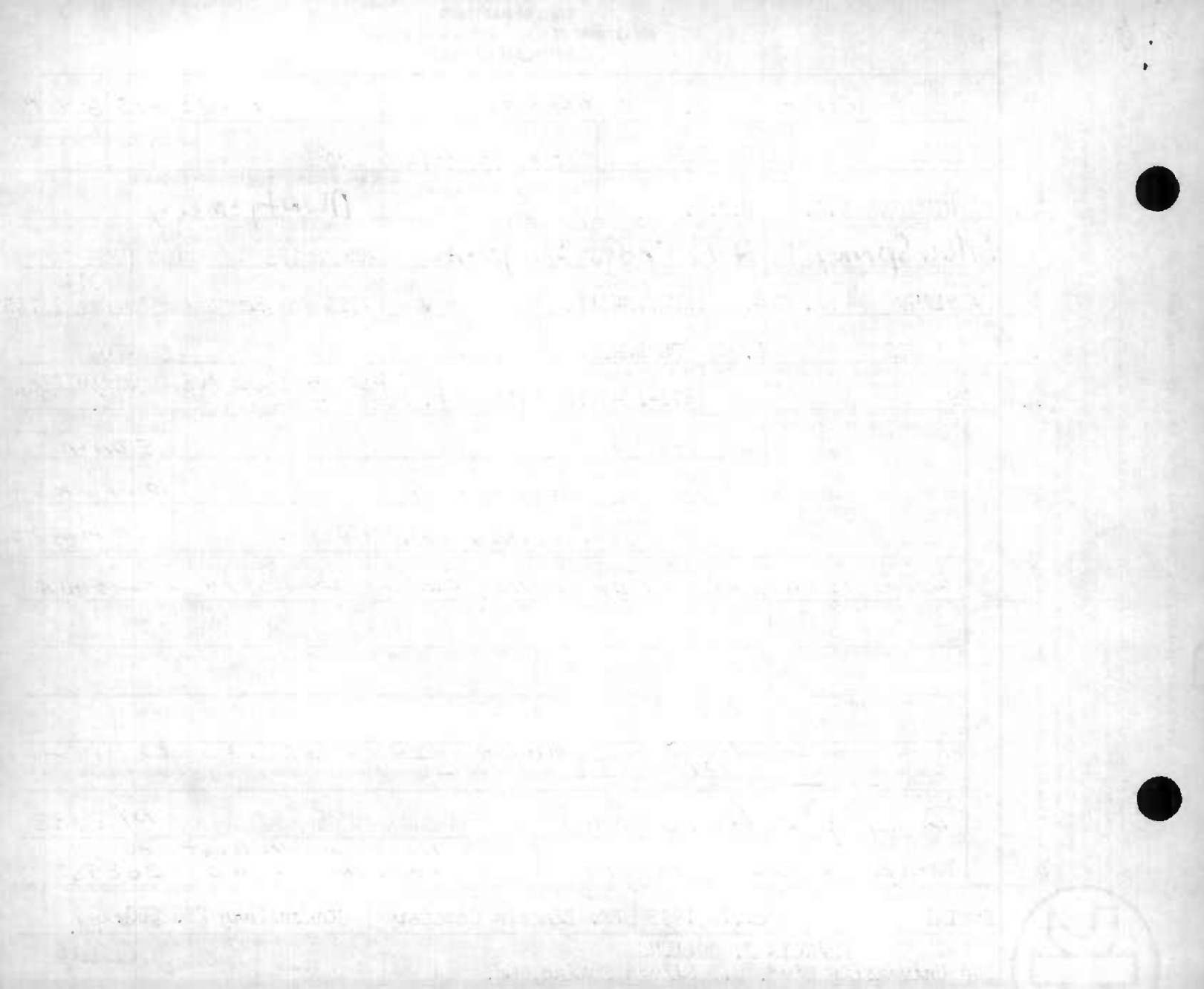
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                         |                                                                       |                                                                                                                                                                        | REG. NO.                                                      |                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>EFFIE A. NEDROW</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10-12-83</b>                |                                                                                                                                                                        | 2b. HOUR<br><b>6:06 P.M.</b>                                  |                                                                                                                            |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>CAUCASIAN</b>                                                                                                             |                                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUGUST 15, 1913</b>                                                                                                           |                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.                                                                          |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WASHINGTON, D.C.</b>                                                                                                                                                                                                                                                                                                                           |  | 7c. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                           |                                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |                                                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                                                                                   |                                                               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>                                                                       |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                  |  |                                                                                                                                         | 13b. CITY OR TOWN<br><b>HYATTSVILLE</b>                               |                                                                                                                                                                        | 13c. STREET ADDRESS<br><b>7333 New Hampshire Avenue 20783</b> |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LOUIS L. PUMPHREY</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EFFIE SPARROW</b> |                                                                                                                                                                        |                                                               |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.<br><b>578-24-3217</b>                                                                                          |                                                                       | 17. INFORMANT<br>ADDRESS<br><b>7333 New Hampshire Ave, Hyattsville, Md.</b><br><b>WILLIAM M. NEDROW - HUSBAND</b>                                                      |                                                               |                                                                                                                            |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>5150 IMMEDIATE CAUSE (a) HYPOXIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CHRONIC PNEUMONITIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>LEFT AXILLARY ABSCESS</b> |  |                                                                                                                                         |                                                                       |                                                                                                                                                                        |                                                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 DAYS</b><br><b>10 WEEKS</b><br><b>10 MONTHS</b>                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>WOUND FROM RADIATION DERMATITIS, CHRONIC LYMPHATIC LEUKEMIA</b>                                                                                                                                                                                         |  |                                                                                                                                         |                                                                       |                                                                                                                                                                        |                                                               |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                        |                                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                   |                                                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                              |                                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                                          |                                                               |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |                                                                       | 21f. LOCATION<br>#STREET CITY OR TOWN COUNTY STATE                                                                                                                     |                                                               |                                                                                                                            |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>MARCH 19 80</b> to <b>OCT 12 19 83</b> , that (I) (we) lost<br>saw the deceased alive on <b>10/11 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                 |  |                                                                                                                                         |                                                                       |                                                                                                                                                                        |                                                               |                                                                                                                            |
| 22b. SIGNATURE<br><b>Daniel Rosenblum MD</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                         |                                                                       | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |                                                               | 22c. DATE SIGNED<br><b>10/12/83</b>                                                                                        |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DANIEL ROSENBLUM, MD</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                         |                                                                       | 22e. ADDRESS<br><b>10400 CONNECTICUT AV<br/>KENSINGTON, MD 20895</b>                                                                                                   |                                                               |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><b>Oct. 15, 1983</b>                                                                                                       |                                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>                                                                                                      |                                                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Bladensburg PR. GEO. Md.</b>                                              |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>FRANCIS J. COLLINS</b><br><b>500 University Blvd. W., Silver Spring, Md.</b>                                                                                                                                                                                                                                                                        |  |                                                                                                                                         |                                                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1983</b>                                                                                                                    |                                                               | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Gish</b>                                                                          |

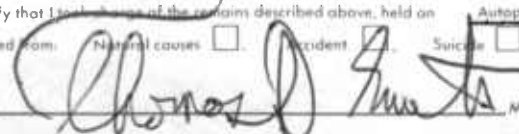
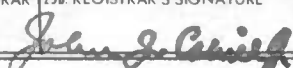
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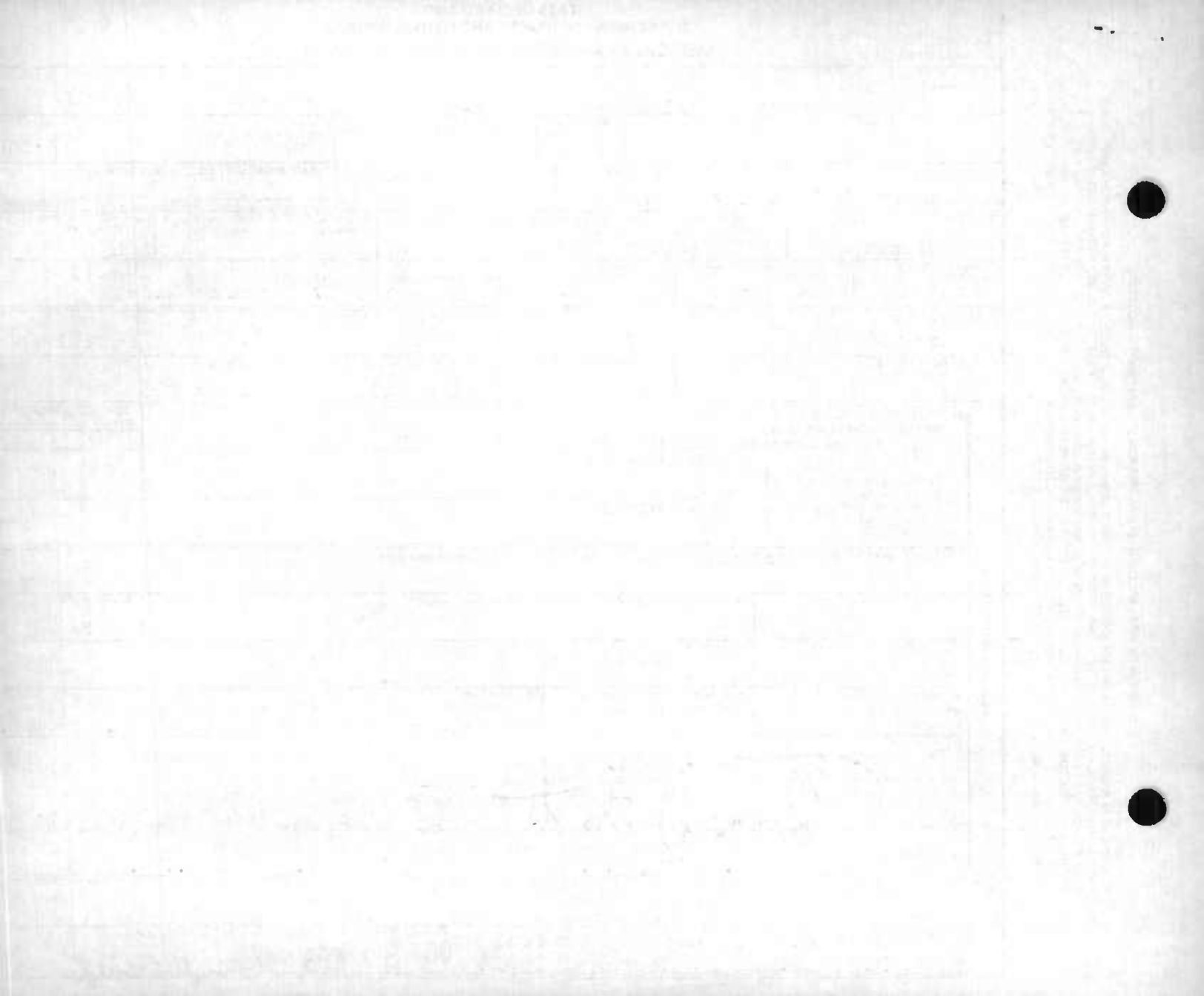
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                          |                         |                                                                                                                                        |  |                                                                                                                    |                                                                                                                                                          |                                                                                                 |                                                                                                     |                                                                                                                     |                                                | REG. NO.                                                                                                                           |                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Laurence Alexander Neustel</b>                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                        |  |                                                                                                                    |                                                                                                                                                          |                                                                                                 | 2a. DATE OF DEATH<br>KNOWN <input checked="" type="checkbox"/> ESTI- MATED <input type="checkbox"/> |                                                                                                                     | MONTH <b>10</b> DAY <b>24</b> YEAR <b>1983</b> |                                                                                                                                    | 2b. HOUR<br><b>9:30P</b> |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                            | 4. RACE<br><b>Negro</b> | 5. DATE OF BIRTH<br>MONTH <b>Mar.</b> DAY <b>22</b> YEAR <b>1982</b>                                                                   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>1</b> YRS.                                                                   | IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b>                                                                                                          | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN <b>0</b>                                                 | 2c. DATE PRONOUNCED DEAD<br><b>10 24 1983</b>                                                       |                                                                                                                     | 2d. HOUR<br><b>9:30P</b>                       |                                                                                                                                    |                          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, D.C.</b>                                                                                                                                                                                                                                                                                             |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                   |  |                                                                                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD.</b>                               |                                                                                                                     |                                                |                                                                                                                                    |                          |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>                                                                                                                                                                                                                                                                                                                     |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4977 Battery Lane</b> |  |                                                                                                                    |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b>                    |                                                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>N/A</b>                                                                     |                                                |                                                                                                                                    |                          |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                    |                         | 13b. CITY OR TOWN<br><b>Montgomery</b>                                                                                                 |  | 13c. CITY OR TOWN<br><b>Bethesda</b>                                                                               |                                                                                                                                                          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                     | 13e. STREET ADDRESS<br><b>4977 Battery Lane (20814)</b>                                                             |                                                |                                                                                                                                    |                          |
| 14. FATHER'S NAME<br>FIRST <b>Laurence</b> MIDDLE <b>Mann</b> LAST <b>Mann</b>                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                        |  |                                                                                                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Paula</b> MIDDLE <b>J.</b> LAST <b>Neustel</b>                                                                      |                                                                                                 |                                                                                                     |                                                                                                                     |                                                |                                                                                                                                    |                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                               |                         |                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br><b>None</b>                                                                            |                                                                                                                                                          | 17. INFORMANT<br>ADDRESS<br><b>Susan Walton, same as #13</b>                                    |                                                                                                     |                                                                                                                     |                                                |                                                                                                                                    |                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9654 IMMEDIATE CAUSE (a) Gunshot wound to head</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                         |                                                                                                                                        |  |                                                                                                                    |                                                                                                                                                          |                                                                                                 |                                                                                                     |                                                                                                                     |                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                       |                          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                              |                         |                                                                                                                                        |  |                                                                                                                    |                                                                                                                                                          |                                                                                                 |                                                                                                     |                                                                                                                     |                                                |                                                                                                                                    |                          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                  |                                                                                                                                                          |                                                                                                 |                                                                                                     | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |                                                |                                                                                                                                    |                          |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                   |                         | 21b. TIME OF INJURY<br>HOUR <b>9:15P</b> MONTH <b>10</b> DAY <b>24</b> YEAR <b>1983</b>                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject shot</b>               |                                                                                                                                                          |                                                                                                 |                                                                                                     |                                                                                                                     |                                                |                                                                                                                                    |                          |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>                                                             |  | 21f. LOCATION<br>STREET <b>4977 Battery Lane</b> CITY OR TOWN <b>Bethesda</b> COUNTY <b>Mont.</b> STATE <b>Md.</b> |                                                                                                                                                          |                                                                                                 |                                                                                                     |                                                                                                                     |                                                |                                                                                                                                    |                          |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                              |                         |                                                                                                                                        |  |                                                                                                                    |                                                                                                                                                          |                                                                                                 |                                                                                                     |                                                                                                                     |                                                | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                          |
| ACTUAL SIGNATURE<br>                                                                                                                                                                                                                                                          |                         | EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>                                                                        |  |                                                                                                                    |                                                                                                                                                          | TITLE (SPECIFY)<br><b>Deputy Chief</b>                                                          |                                                                                                     | DATE SIGNED<br><b>10/25/83</b>                                                                                      |                                                | MEDICAL EXAMINER                                                                                                                   |                          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                       |                         | 23b. DATE<br><b>Oct 28, 1983</b>                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ukiah Cemetery</b>                                                        |                                                                                                                                                          |                                                                                                 |                                                                                                     | 23d. LOCATION<br>CITY OR TOWN <b>Ukiah, California</b> COUNTY <b>California</b> STATE <b>California</b>             |                                                |                                                                                                                                    |                          |
| 24. FUNERAL DIRECTOR<br>NAME <b>Robert A. Pumphrey</b> ADDRESS <b>Homes, P.A. Bethesda, Maryland 20814</b>                                                                                                                                                                                                                                                       |                         |                                                                                                                                        |  |                                                                                                                    |                                                                                                                                                          | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 31 1983</b>                                             |                                                                                                     | 25b. REGISTRAR'S SIGNATURE<br> |                                                |                                                                                                                                    |                          |

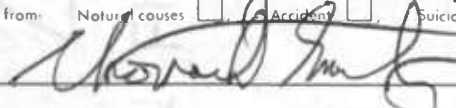
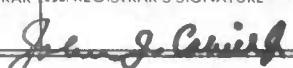


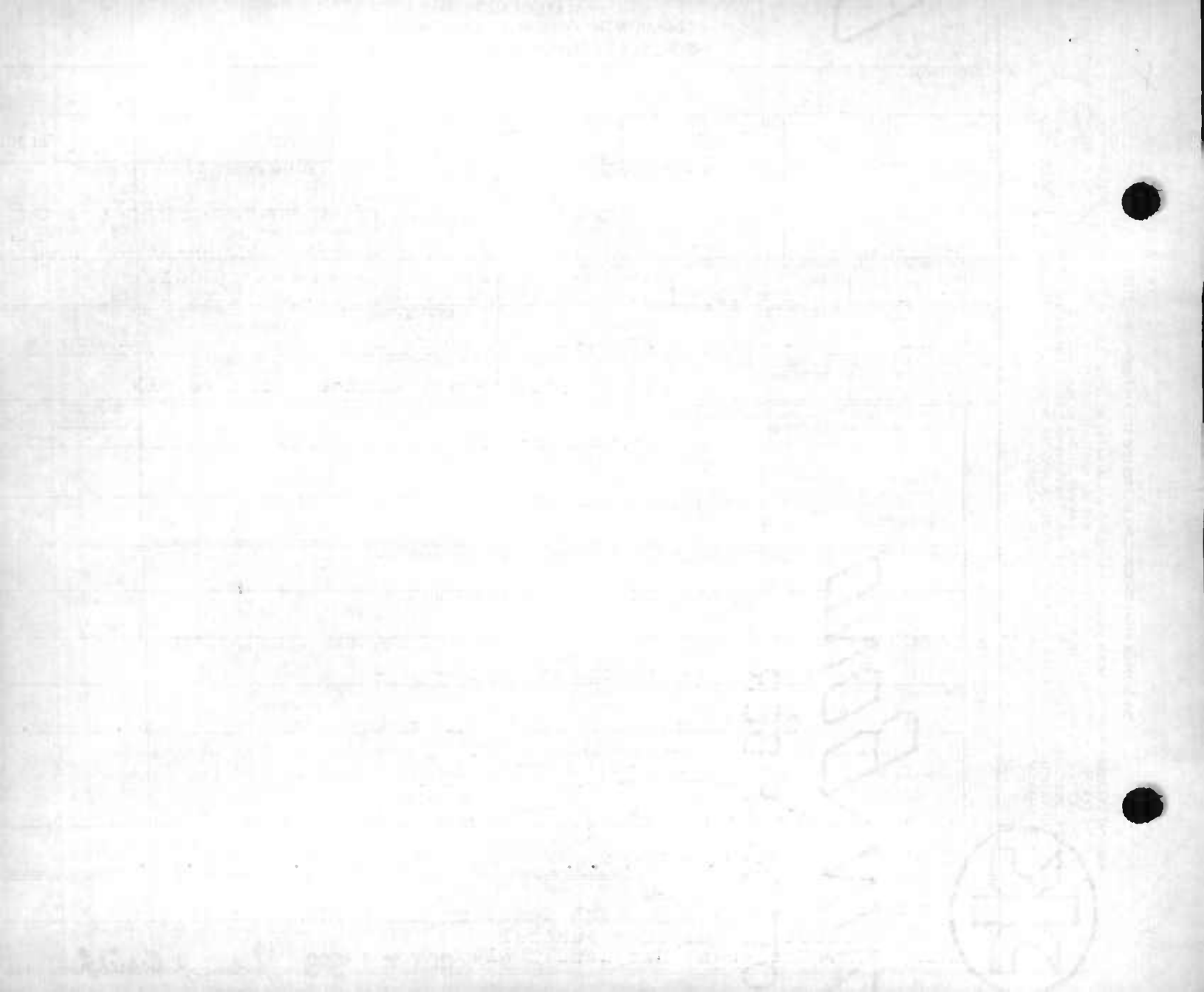


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                 |  |                                                                                                                                  |  |                                                                                                                                                          |  |                                                                                                            |  |                                                                                                                  |  | REG. NO.                                                                                                                           |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Paula J. Neustel</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                  |  |                                                                                                                                                          |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>10</b> DAY <b>24</b> YEAR <b>1983</b> |  | 2b. HOUR <b>9:30</b>                                                                                             |  | 2c. DATE OF DEATH <input type="checkbox"/> MONTH <b>10</b> DAY <b>24</b> YEAR <b>1983</b>                                          |  |
| 3. SEX <b>Female</b>                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE <b>Cauc.</b>                                                                                                             |  | 5. DATE OF BIRTH<br>MONTH <b>Jan.</b> DAY <b>3</b> YEAR <b>1949</b>                                                                                      |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>34</b> YRS.                                                             |  | 7. IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>                                                                  |  | 7c. DATE PRONOUNCED DEAD <b>10 24 1983</b>                                                                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Oregon</b>                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>                                                                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>                                         |  |                                                                                                                  |  |                                                                                                                                    |  |
| 10. CITY OR TOWN OF DEATH <b>Bethesda</b>                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4977 Battery Lane</b> |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Systems Consultant</b>                    |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Health Care</b>                                                             |  |                                                                                                                                    |  |
| 13a. STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                              |  | 13b. CITY <b>Montgomery</b>                                                                                                      |  | 13c. CITY OR TOWN <b>Bethesda</b>                                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |  | 13e. STREET ADDRESS (20814) <b>4977 Battery Lane</b>                                                             |  |                                                                                                                                    |  |
| 14. FATHER'S NAME<br>FIRST <b>Donald</b> MIDDLE <b>Eugene</b> LAST <b>Neustel</b>                                                                                                                                                                                                                                                                                       |  |                                                                                                                                  |  |                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Lois</b> MIDDLE <b>Elwood</b> LAST <b>Elwood</b>                      |  |                                                                                                                  |  |                                                                                                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                  |  | 16b. SOCIAL SECURITY NO. <b>549-70-9536</b>                                                                                                              |  | 17. INFORMANT ADDRESS <b>Susan Walton, same as #13</b>                                                     |  |                                                                                                                  |  |                                                                                                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>9654</b> IMMEDIATE CAUSE (a) <b>Gunshot wound to head</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                                  |  |                                                                                                                                                          |  |                                                                                                            |  |                                                                                                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                                          |  |                                                                                                                                  |  |                                                                                                                                                          |  |                                                                                                            |  |                                                                                                                  |  |                                                                                                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                        |  |                                                                                                            |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  |                                                                                                                                    |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                          |  |                                                                                                                                  |  | 21b. TIME OF INJURY HOUR <b>9:15</b> MONTH <b>10</b> DAY <b>25</b> YEAR <b>1983</b>                                                                      |  |                                                                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject shot</b>                |  |                                                                                                                                    |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                       |  |                                                                                                                                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>                                                                                  |  |                                                                                                            |  | 21f. LOCATION STREET <b>4977 Battery Lane</b> CITY OR TOWN <b>Bethesda</b> COUNTY <b>Mont.</b> STATE <b>Md.</b>  |  |                                                                                                                                    |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                                   |  |                                                                                                                                  |  |                                                                                                                                                          |  |                                                                                                            |  |                                                                                                                  |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                     |  |                                                                                                                                  |  | TITLE (SPECIFY) <b>Deputy Chief</b>                                                                                                                      |  |                                                                                                            |  | DATE SIGNED <b>10/25/83</b>                                                                                      |  |                                                                                                                                    |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                  |  | ADDRESS <b>111 Penn St. Balto., MD.</b>                                                                                                                  |  |                                                                                                            |  |                                                                                                                  |  |                                                                                                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                  |  | 23b. DATE <b>October 28, 1983</b>                                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Ukiah Cemetery</b>                                                   |  | 23d. LOCATION CITY OR TOWN <b>Ukiah, California</b> COUNTY <b>California</b> STATE <b>California</b>             |  |                                                                                                                                    |  |
| 24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814</b>                                                                                                                                                                                                                                                                        |  |                                                                                                                                  |  |                                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 31 1983</b>                                                           |  | 25b. REGISTRAR'S SIGNATURE  |  |                                                                                                                                    |  |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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DATE OF DEATH                                                                                                                                           |                                                                  | 2b. HOUR                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |
| FIRST MIDDLE LAST<br><b>SACHIE Nishio</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              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RACE                                                                                                   | 5. DATE OF BIRTH                                                                                                                                            | 6. AGE                                                           |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |
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| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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CITIZEN OF WHAT COUNTRY?                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |
| Washington, D.C.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       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| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |
| BETHESDA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               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| 13a. RESIDENCE<br>(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     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| 14. 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| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          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| 18. 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| 20. 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| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      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| 21b. TIME OF INJURY<br>HOUR A.M. 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| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               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| 21d. 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| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        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| 21f. 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| 22. I certify that (I) (this hospital) attended the deceased from 8/5 19 83 to 10/6 19 83 that (I) (we) last saw the deceased alive on 10/4/83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body of deceased)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        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| 23. 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| 24. 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| 26. DATE REC'D. BY REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             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| 27. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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| 28. DATE OF BURIAL, CREMATION, REMOVAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       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| 29. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            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| 30. LOCATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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| 31. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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| 32. DATE REC'D. BY REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             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| 33. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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34. FUNERAL DIRECTOR  
NAME Tyson Wheeler Funeral Home, Inc.  
1331 Rockville Pike Rockville, Maryland 20852

35. DATE REC'D. BY REGISTRAR  
OCT 14 1983

36. REGISTRAR'S SIGNATURE  
John J. Lohr

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                |  |                                                                                                                                         |                                                     |                                                                                                                                                          |                            |                                                                                              |  |
|----------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Celta</b> <b>Norken</b> |  |                                                                                                                                         | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10-23-83</b> |                                                                                                                                                          | 2b. HOUR<br><b>8:30P</b> M |                                                                                              |  |
| 3. SEX<br><b>FEMALE</b>                                        |  | 4. RACE<br><b>White</b>                                                                                                                 |                                                     | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>6-15-92</b>                                                                                                        |                            | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>91</b> YRS.                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                           |                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY COUNTY</b> MD.                         |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSPITAL</b> |                                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                                                                     |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>                                         |  |
| 13a. STATE<br><b>MARYLAND</b>                                  |  | 13b. COUNTY<br><b>MONTGOMERY</b>                                                                                                        |                                                     | 13c. CITY OR TOWN<br><b>SILVER SPRING</b>                                                                                                                |                            | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>MAVER</b>            |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>SARAH</b> (UNASCERTAINABLE)                                                            |                                                     | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                            |                            | 16b. SOCIAL SECURITY NO.<br><b>579-70-7498</b>                                               |  |
| 17. INFORMANT<br><b>MYER NORKEN,</b>                           |  | ADDRESS<br><b>2304 COLERIDGE DRIVE<br/>SILVER SPRING, MARYLAND</b>                                                                      |                                                     |                                                                                                                                                          |                            |                                                                                              |  |

|                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>5303 esophageal obstruction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b> |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**chronic senility**

|                        |  |                                                  |  |                                                                                   |  |                                                                                                                         |  |
|------------------------|--|--------------------------------------------------|--|-----------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
|------------------------|--|--------------------------------------------------|--|-----------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|

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|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------|--|-------------------------------------------------------------------------------|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------|--|-------------------------------------------------------------------------------|--|--|--|

|                                                                                                                                                          |  |                                                                     |  |                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|------------------------------------------------|--|
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|------------------------------------------------|--|

|                                                                                                                                                                                                                                                                                                                                          |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 17, 1983</b> to <b>Oct 23, 1983</b> , that (I) (we) last saw the deceased alive on <b>Oct 21, 1983</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|

|                                       |  |                                                                                                                                                             |  |                                     |  |
|---------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------|--|
| 22b. SIGNATURE<br><b>Mark S Rosen</b> |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10/24/83</b> |  |
|---------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------|--|

|                                                                  |  |                                                                  |  |  |  |
|------------------------------------------------------------------|--|------------------------------------------------------------------|--|--|--|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mark S Rosen, MD</b> |  | 22e. ADDRESS<br><b>3929 FERRARA DRIVE<br/>Silver Spring, MD.</b> |  |  |  |
|------------------------------------------------------------------|--|------------------------------------------------------------------|--|--|--|

|                                                  |  |                                |  |                                                                        |  |                                                                     |  |
|--------------------------------------------------|--|--------------------------------|--|------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b> |  | 23b. DATE<br><b>10/25/1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OSHEV SHOLOM TALMUD TORAH</b> |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>WASHINGTON, D. C.</b> |  |
|--------------------------------------------------|--|--------------------------------|--|------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|

|                                                                                               |  |                             |  |                                                     |  |                                 |  |
|-----------------------------------------------------------------------------------------------|--|-----------------------------|--|-----------------------------------------------------|--|---------------------------------|--|
| 23e. NAME OF CEMETERY<br><b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL-CONGREGATION CEMETERY</b> |  | 23f. ADDRESS<br><b>HOME</b> |  | 23g. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b> |  | 23h. DATE<br><b>OCT 27 1983</b> |  |
|-----------------------------------------------------------------------------------------------|--|-----------------------------|--|-----------------------------------------------------|--|---------------------------------|--|

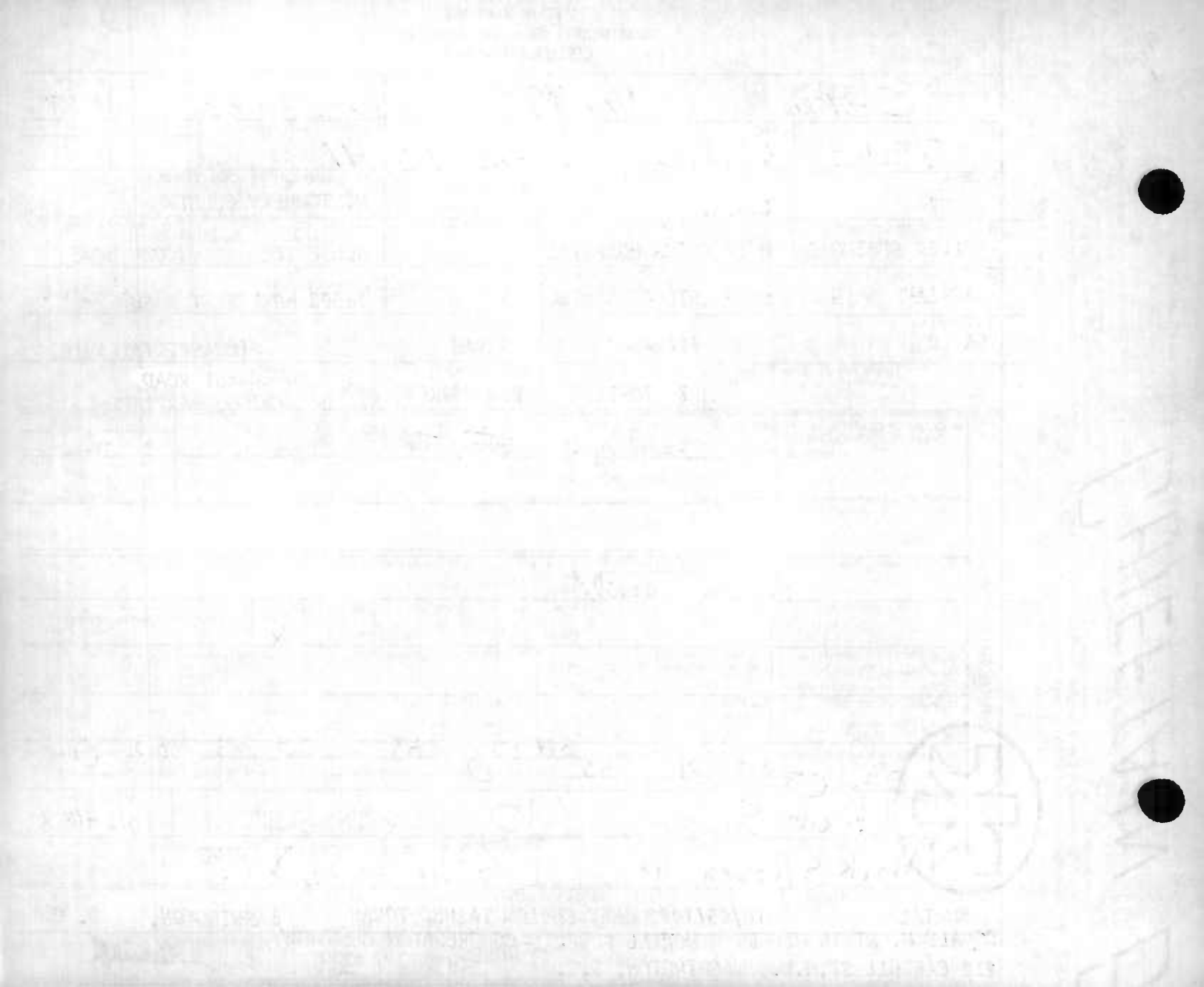
|                                                               |  |  |  |  |  |  |  |
|---------------------------------------------------------------|--|--|--|--|--|--|--|
| 23i. ADDRESS<br><b>232 CARROLL ST, N.W., WASHINGTON, D.C.</b> |  |  |  |  |  |  |  |
|---------------------------------------------------------------|--|--|--|--|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Papers may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

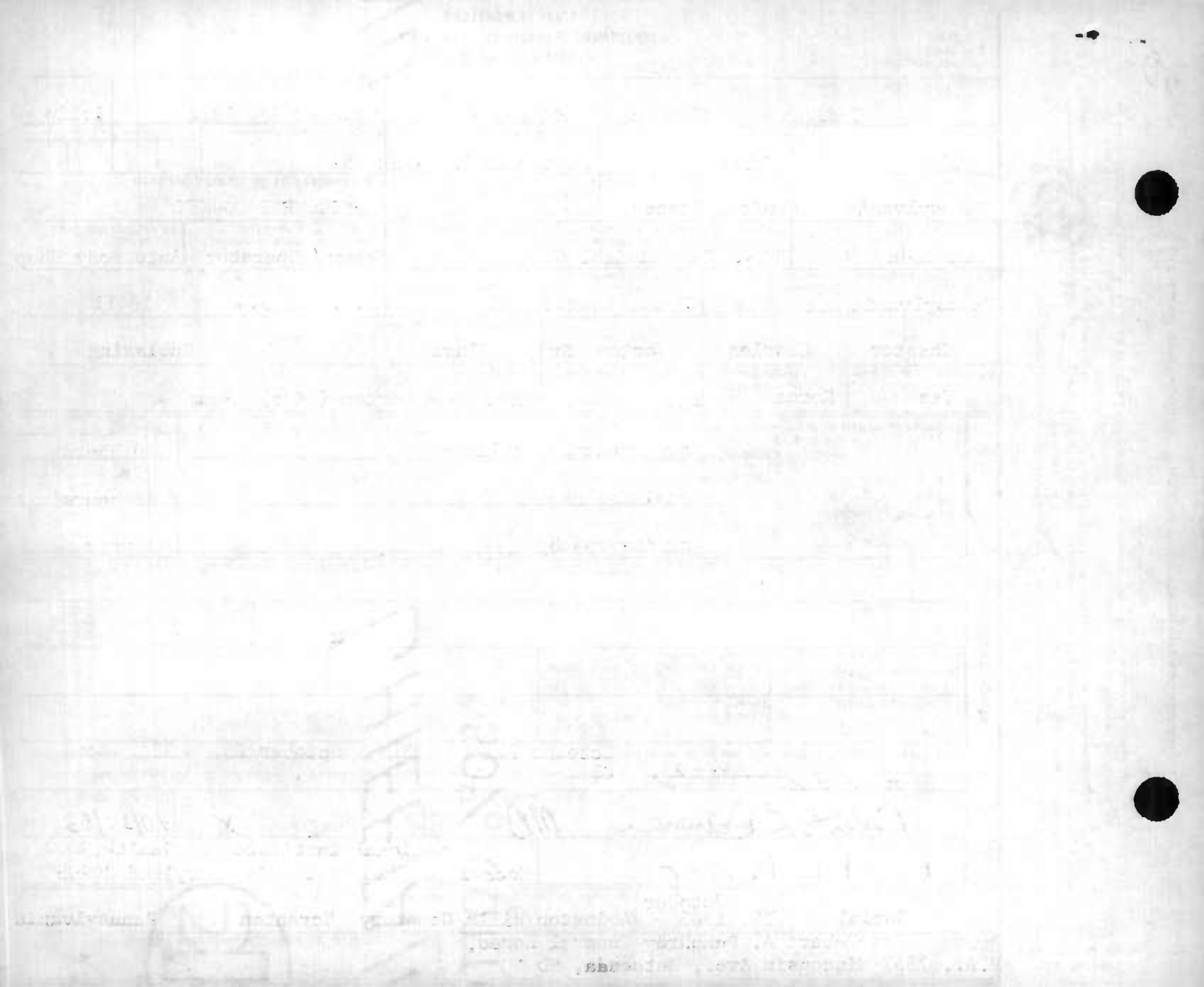
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                       |                                                      |                                                                                                                                                                 |  |                                                                                                 |  |                                                                                                                                       |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>CHESTER CHARLES NORTON JR                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       | 2a. DATE OF DEATH MONTH DAY YEAR<br>October 25, 1983 |                                                                                                                                                                 |  | 2b. HOUR<br>1:22p M                                                                             |  |                                                                                                                                       |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>White                                                                                                                      |                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>September 21, 1932                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>51 YRS                                                       |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                                    |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 9. CITIZEN OF WHAT COUNTRY?<br>United States                                                                                          |                                                      | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY COUNTY MD.                                  |  |                                                                                                                                       |  |
| 12. CITY OR TOWN OF DEATH<br>Bethesda                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NIH, The Clinical Center |                                                      |                                                                                                                                                                 |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Owner/ Operator              |  | 15. KIND OF BUSINESS OR INDUSTRY<br>Auto Body Shop                                                                                    |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE<br>Pennsylvania                                                                                                                                                                                                                                                                                                                                                                                              |  | 16b. COUNTY<br>Lackawanna                                                                                                             |                                                      | 16c. CITY OR TOWN<br>Clarks Summit                                                                                                                              |  | 16d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 16e. STREET ADDRESS<br>RD #2<br>P.O. Box 574<br>18411                                                                                 |  |
| 17. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Chester Charles Norton Sr                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |                                                      | 18. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Clara Zublasing                                                                                                |  |                                                                                                 |  |                                                                                                                                       |  |
| 19a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 19b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>Korea                                                                      |                                                      | 20. INFORMANT ADDRESS<br>Mrs. Joan Norton (wife) Same                                                                                                           |  |                                                                                                 |  |                                                                                                                                       |  |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>4254 IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Renal failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Cardiomyopathy</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                     |  |                                                                                                                                       |                                                      |                                                                                                                                                                 |  |                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>20 hours<br>48 hours<br>1 year                                                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                       |                                                      |                                                                                                                                                                 |  |                                                                                                 |  |                                                                                                                                       |  |
| 22a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 22b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |                                                      |                                                                                                                                                                 |  | 22c. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 22d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                               |  | 23b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                            |                                                      | 23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                  |  |                                                                                                 |  |                                                                                                                                       |  |
| 24a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>(AT WORK) (AT WORK)                                                                                                                                                                                                                                                                                                                                                                                                       |  | 24b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |                                                      | 24c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                               |  |                                                                                                 |  |                                                                                                                                       |  |
| 25. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 7, 1983</u> , to <u>October 25, 1983</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>October 25, 1983</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. |  |                                                                                                                                       |                                                      |                                                                                                                                                                 |  |                                                                                                 |  |                                                                                                                                       |  |
| 26. SIGNATURE<br><u>Robert L. Danner</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                       |                                                      | 26a. DEGREE<br>MD<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                                                                                 |  | 26b. DATE SIGNED<br>10/25/83                                                                                                          |  |
| 27. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert L. Danner                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                       |                                                      | 27a. ADDRESS<br>National Institutes of Health, 9000 Rockville Pike, Bethesda, Maryland 20205                                                                    |  |                                                                                                 |  |                                                                                                                                       |  |
| 28. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28a. DATE<br>October 29, 1983                                                                                                         |                                                      | 28b. NAME OF CEMETERY OR CREMATORY<br>Abington Hills Cemetery                                                                                                   |  | 28c. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Scranton Pennsylvania                             |  | 28d. DATE REC'D. BY REGISTRAR                                                                                                         |  |
| 29. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A., 7557 Wisconsin Ave., Bethesda, MD                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                       |                                                      |                                                                                                                                                                 |  |                                                                                                 |  |                                                                                                                                       |  |
| 30. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                       |                                                      |                                                                                                                                                                 |  |                                                                                                 |  |                                                                                                                                       |  |

OCT 31 1983



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                         |  |                                                                                                                                     |                                                          |                                                                                                                                                             |  |                                                                                           |  |
|-------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Wlaine C. Norton</i>                                                             |  |                                                                                                                                     | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>Oct. 31, 1983</i> |                                                                                                                                                             |  | 2b. HOUR<br><i>8:50 PM</i>                                                                |  |
| 3. SEX<br><i>Female</i>                                                                                                 |  | 4. RACE<br><i>white</i>                                                                                                             |                                                          | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>10 17 44</i>                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>39</i> YRS                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Wash DC</i>                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                          |                                                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery County MD.</i>                      |  |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Holy Cross Hosp</i> |                                                          |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Latha Operator</i> |  |
| 13a. USUAL RESIDENCE (IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><i>Rn</i> |  | 13c. CITY OR TOWN<br><i>Mountaintop</i>                                                                                             |                                                          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                        |  | 13e. STREET ADDRESS<br><i>P.O. Box 212</i>                                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>John E. Burroughs</i>                                                      |  |                                                                                                                                     |                                                          | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Mary Redding</i>                                                                                        |  |                                                                                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>                                       |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>213-46-8489</i>                                                       |                                                          | 17. INFORMANT<br>ADDRESS<br><i>Mary Burroughs 2409 Lackawanna St. Adelphi, MD 20783</i>                                                                     |  |                                                                                           |  |

|                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Respiratory Failure</i><br><i>1579</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Aspiration</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Cancer of Pancreas</i><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>6 mo</i> |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.  
*Bladder CA*

|                                                                                                                                                                                                                      |  |                                                                                                |  |                                                                                                |  |                                                                                                                                       |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION<br><i>8/25/83</i>                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Nephroectomy tube insertion/failure</i> |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>6 19 83</i>                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                 |  |                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><i>3947 Ferrara Dr. Wheaton, MD 20706</i> |  |                                                                                                                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/31 19 83</i> to <i>10/31 19 83</i> , that (I) (we) last saw the deceased alive on above (I) (we) (did) (did not) view the body after death. |  |                                                                                                |  |                                                                                                |  |                                                                                                                                       |  |
| 22b. SIGNATURE<br><i>Peter B. Sherer</i>                                                                                                                                                                             |  |                                                                                                |  | DEGREE<br><i>MD</i>                                                                            |  | 22c. DATE SIGNED<br><i>11/1/83</i>                                                                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Peter B. Sherer</i>                                                                                                                                                      |  |                                                                                                |  | 22e. ADDRESS<br><i>3947 Ferrara Dr. Wheaton, MD 20706</i>                                      |  |                                                                                                                                       |  |

|                                                               |  |                             |  |                                                                 |  |                                                                          |  |
|---------------------------------------------------------------|--|-----------------------------|--|-----------------------------------------------------------------|--|--------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i> |  | 23b. DATE<br><i>11-3-83</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>St. Francis Xavier</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Gettysburg Adams PA</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Robert J. Monahan</i>      |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 3 1983</i>              |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Conner</i>                      |  |
| 26. ADDRESS<br><i>125 Carlisle St., Gettysburg, PA 17325</i>  |  |                             |  |                                                                 |  |                                                                          |  |



## CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ethel Odessa Patteson                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10/23/83                                                 |                                                                                      | 2b. HOUR<br>150 P.M.                                                                                                       |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                          | 4. RACE<br>Caucasian                                                                                                                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 12 00                                                                                                               |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.                                           | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia                                                                                                                                                                                                                                                                                                                                                                     | 7b. CITIZEN OF WHAT COUNTRY?<br>United States                                                                                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                                   |                                                                                      |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>Rockville                                                                                                                                                                                                                                                                                                                                                                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Collingswood Nursing Home |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                                        |                                                                                                                            |
| 13a. STATE<br>Virginia                                                                                                                                                                                                                                                                                                                                                                                                    | 13b. COUNTY<br>Roanoke                                                                                                                 | 13c. CITY OR TOWN<br>Vinton                                                                                                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>102 Mitchell Road                                             |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Emmet G. Coleman                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annie Arrington                                |                                                                                      |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                        | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>N/A                                                                                             | 17. INFORMANT (Son) ADDRESS<br>Herbert Patteson, Woodstock, VA                                  |                                                                                      |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 5168 Chronic intestinal pneumonia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>years |                                                                                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                       |                                                                                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                  |                                                                                                                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                 |                                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/13 19 82, to 10/23 19 82, that (I) (we) last saw the deceased alive on 10/22 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                        |                                                                                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
| 22b. SIGNATURE<br>John R. Melnich my                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                        | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                                                                                 | 22c. DATE SIGNED<br>10/23/83                                                         |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John R. Melnich my                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                        | 22e. ADDRESS<br>16220 Frederick Road - Gaithersburg, Md 20877                                                                                               |                                                                                                 |                                                                                      |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                       | 23b. DATE<br>October 26, 1983                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY<br>Mountain View                                                                                                         |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Vinton Roanoke Virginia                |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland                                                                                                                                                                                                                                                                                                                        |                                                                                                                                        | 25a. DATE REC'D. BY REGISTRAR<br>OCT 25 1983                                                                                                                |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver                                         |                                                                                                                            |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 8 0 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                             |  |                                                                                                                                   |                                                  |                                                                                                                                                          |                                        |                                                                                                      |                                                                                   |                                                         |                                                   |  |
|-----------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|---------------------------------------------------------|---------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FRANCES D PAXTON</b>                 |  |                                                                                                                                   | 2a. DATE OF DEATH MONTH DAY YEAR <b>10/13/83</b> |                                                                                                                                                          |                                        | 2b. HOUR <b>5:38</b> M.                                                                              |                                                                                   |                                                         |                                                   |  |
| 3. SEX <b>FEMALE</b>                                                        |  | 4. RACE <b>CAUCASIAN</b>                                                                                                          |                                                  | 5. DATE OF BIRTH MONTH DAY YEAR <b>NOV. 13, 1911</b>                                                                                                     |                                        | 6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.                                                       |                                                                                   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |                                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, DC</b>             |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                        |                                                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                        | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.                                           |                                                                                   |                                                         |                                                   |  |
| 10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b> |                                                  |                                                                                                                                                          |                                        | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>                       |                                                                                   | 12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>       |                                                   |  |
| 13a. STATE <b>MARYLAND</b>                                                  |  |                                                                                                                                   | 13b. COUNTY <b>MONTGOMERY</b>                    |                                                                                                                                                          | 13c. CITY OR TOWN <b>SILVER SPRING</b> |                                                                                                      | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                         | 13e. STREET ADDRESS <b>9903 ROGART ROAD 20901</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>ROBERT GRAMM</b>                     |  |                                                                                                                                   |                                                  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ADELAIDE LYNCH</b>                                                                                         |                                        |                                                                                                      |                                                                                   |                                                         |                                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> |  |                                                                                                                                   |                                                  | 16b. SOCIAL SECURITY NO. <b>579-22-0978</b>                                                                                                              |                                        | 17. INFORMANT <b>9903 Rogart Road Silver Spring, Md. 20901</b><br><b>FRANCIS J. PAXTON - HUSBAND</b> |                                                                                   |                                                         |                                                   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Respiratory Failure**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**6 months****7383**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

**Chronic obstructive lung disease****3 yrs**

DUE TO, OR AS A CONSEQUENCE OF

**Chest wall deformity****20 yrs**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**I degenerative hypertrophic subarterial stenosis**

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☒YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (1) (this hospital) attended the deceased from **10/13**, 19 **83**, to **10/13**, 19 **83**, that (1) (we) lost saw the deceased alive on **10/13**, 19 **83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN

MEDICAL DIRECTOR ☒STAFF PHYSICIAN ☐

22c. DATE SIGNED

**10/13/83**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

**Ernest Oser, M.D.****10301 Georgia Avenue Silver Spring, Md. 20902**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION CITY OR TOWN

COUNTY

STATE

**Burial****10/17/83****GATE OF HEAVEN CEMETERY SILVER SPRING, MONT. MARYLAND**

24. FUNERAL DIRECTOR NAME

**FRANCIS J. COLLINS**

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

**500 University Blvd. W. SILVER SPRING, MD. 20901****OCT 21 1983****John J. Collins**

BP

DHMH - 16 50M 4/82

(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Post-mortem by retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.



11



200-1001

CHIEFMAN



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

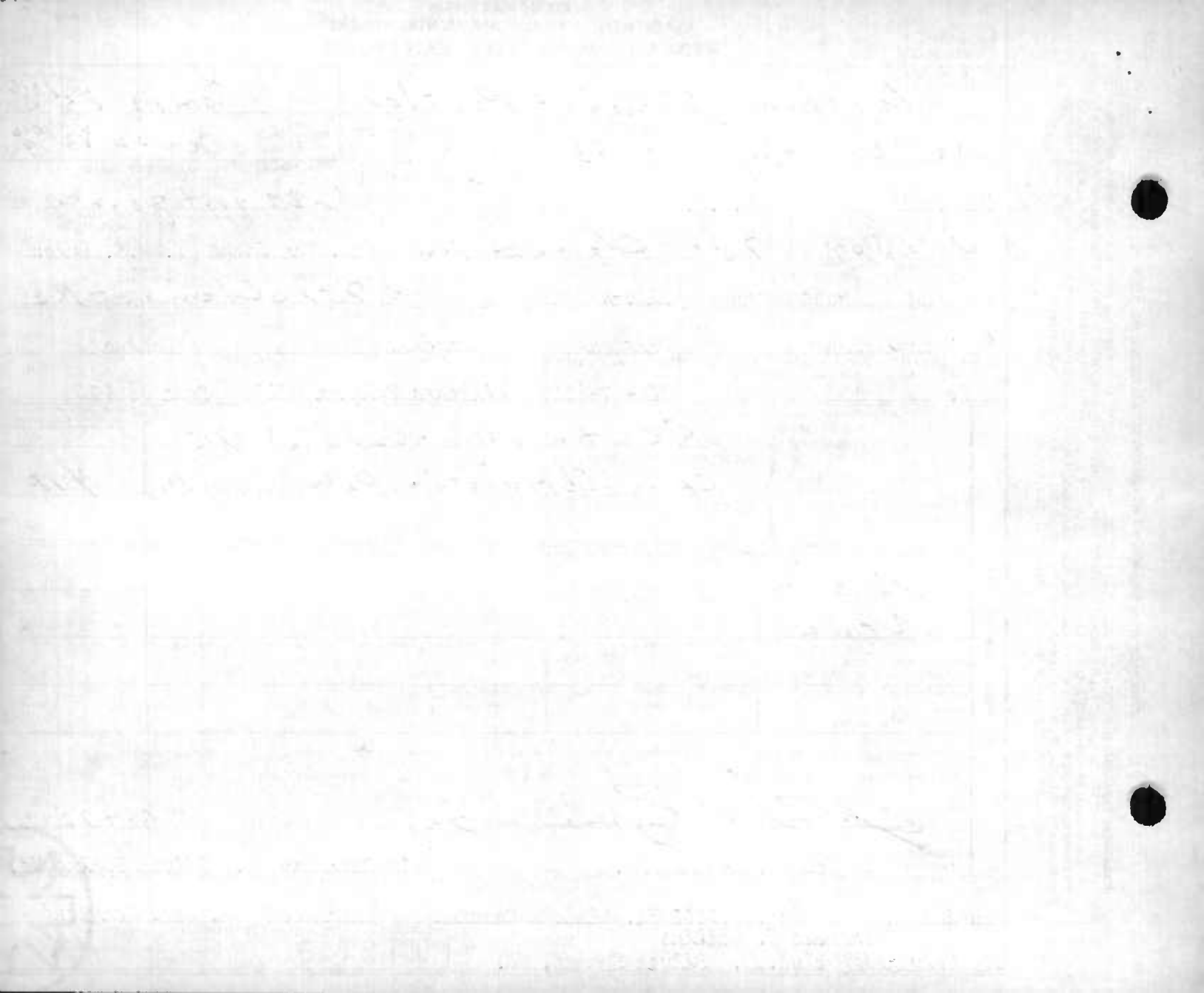
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     |                                                                                                                                      |                                                     |                                                                                                                                                             |                                           |                                                                                                      |                                                     |                                                                                     |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>William Vincent Peitler</u>                                                                                                                                                                                                                                                                                                                                                                                     |                     |                                                                                                                                      |                                                     | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <u>Oct 22 1983</u>                                                                                                     |                                           |                                                                                                      |                                                     | 2b. HOUR<br><u>10:16</u> AM                                                         |  |
| 3. SEX<br><u>M</u>                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4. RACE<br><u>W</u> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <u>Aug 18 1873</u>                                                                                | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <u>73</u> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN                                                                                                                     | IF UNDER 24 HRS.<br>HOURS MIN             | 7c. DATE PRONOUNCED DEAD<br><u>Oct 22 1983</u>                                                       | 2d. HOUR<br><u>10:16</u> AM                         |                                                                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>New York</u>                                                                                                                                                                                                                                                                                                                                                                                           |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                        |                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Montgomery</u> MD                                         |                                                     |                                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br><u>Silver Spring</u>                                                                                                                                                                                                                                                                                                                                                                                                      |                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>9510 Clement Rd</u> |                                                     |                                                                                                                                                             |                                           | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Gen. President T. M.S. Union</u> |                                                     | 12b. KIND OF BUSINESS OR INDUSTRY                                                   |  |
| 13a. STATE<br><u>Maryland</u>                                                                                                                                                                                                                                                                                                                                                                                                                          |                     |                                                                                                                                      |                                                     | 13b. CITY OR TOWN<br><u>Montgomery</u>                                                                                                                      | 13c. CITY OR TOWN<br><u>Silver Spring</u> | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      | 13e. STREET ADDRESS<br><u>20910 9510 Clement Rd</u> |                                                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Maximillian Peitler</u>                                                                                                                                                                                                                                                                                                                                                                                   |                     |                                                                                                                                      |                                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Margaret Hartnet</u>                                                                                    |                                           |                                                                                                      |                                                     |                                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><u>No</u>                                                                                                                                                                                                                                                                                                                                                                     |                     |                                                                                                                                      |                                                     | 16b. SOCIAL SECURITY NO.<br><u>066-07-8869</u>                                                                                                              |                                           | 17. INFORMANT<br><u>Alberta Peitler Wife</u> ADDRESS<br><u>Same as 13</u>                            |                                                     |                                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>4960<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <u>Chronic Obstructive Pulmonary Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Yrca</u>                                 |                     |                                                                                                                                      |                                                     |                                                                                                                                                             |                                           |                                                                                                      |                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><u>None</u>                                                                                                                                                                                                                                                                                                     |                     |                                                                                                                                      |                                                     |                                                                                                                                                             |                                           |                                                                                                      |                                                     |                                                                                     |  |
| 19a. DATE OF OPERATION<br><u>None</u>                                                                                                                                                                                                                                                                                                                                                                                                                  |                     |                                                                                                                                      |                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                           |                                           |                                                                                                      |                                                     | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                 |                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                           |                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                           |                                                                                                      |                                                     |                                                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                              |                     | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                          |                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                           |                                                                                                      |                                                     |                                                                                     |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                     |                                                                                                                                      |                                                     |                                                                                                                                                             |                                           |                                                                                                      |                                                     |                                                                                     |  |
| ACTUAL SIGNATURE<br><u>John S. Rogers</u>                                                                                                                                                                                                                                                                                                                                                                                                              |                     |                                                                                                                                      |                                                     | TITLE (SPECIFY)<br>M.D. <u>Doc</u>                                                                                                                          |                                           | MEDICAL EXAMINER                                                                                     |                                                     | DATE SIGNED<br><u>Oct 22 1983</u>                                                   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <u>John S. Rogers, Md.</u>                                                                                                                                                                                                                                                                                                                                                                                          |                     |                                                                                                                                      |                                                     | ADDRESS <u>1919 Seminary Rd. Silver Spring, Md.</u>                                                                                                         |                                           |                                                                                                      |                                                     |                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                          |                     | 23b. DATE<br><u>Oct. 25, 1983</u>                                                                                                    |                                                     | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Ft. Lincoln Cemetery</u>                                                                                           |                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Brentwood Pr. Geo. Maryland</u>                     |                                                     |                                                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Francis J. Collins</u>                                                                                                                                                                                                                                                                                                                                                                                              |                     |                                                                                                                                      |                                                     | 25a. DATE REC'D. BY REGISTRAR<br><u>OCT 27 1983</u>                                                                                                         |                                           | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Collins</u>                                                 |                                                     |                                                                                     |  |
| 500 University Blvd., W. Silver Spring, Md.                                                                                                                                                                                                                                                                                                                                                                                                            |                     |                                                                                                                                      |                                                     |                                                                                                                                                             |                                           |                                                                                                      |                                                     |                                                                                     |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                |  |  |                                                                                                                           |  |  |                                                                                                                                                                    |  |  |                                                                     |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------|--|--|
| 1 - FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                             |  |  | REG. NO.                                                                                                                  |  |  |                                                                                                                                                                    |  |  |                                                                     |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                     |  |  | FIRST MARY                                                                                                                |  |  | MIDDLE S.                                                                                                                                                          |  |  | LAST PENNING                                                        |  |  |
| 3 SEX                                                                                                                                                                                                                                                                                                               |  |  | 4 RACE                                                                                                                    |  |  | 5 DATE OF BIRTH                                                                                                                                                    |  |  | 2a DATE OF DEATH                                                    |  |  |
| Female                                                                                                                                                                                                                                                                                                              |  |  | Caucasian                                                                                                                 |  |  | June 28 1897                                                                                                                                                       |  |  | 10-5-83                                                             |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                            |  |  | 7b CITIZEN OF WHAT COUNTRY?                                                                                               |  |  | 8 MARRIED: <input checked="" type="checkbox"/> EVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |  |
| Germany                                                                                                                                                                                                                                                                                                             |  |  | United States                                                                                                             |  |  |                                                                                                                                                                    |  |  | Montgomery County MD.                                               |  |  |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                            |  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                     |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                       |  |  | 12b KIND OF BUSINESS OR INDUSTRY                                    |  |  |
| Silver Spring MD                                                                                                                                                                                                                                                                                                    |  |  | Althea Woodland Nursy Home                                                                                                |  |  | Homemaker                                                                                                                                                          |  |  | Home                                                                |  |  |
| 13a STATE                                                                                                                                                                                                                                                                                                           |  |  | 13b COUNTY                                                                                                                |  |  | 13c CITY OR TOWN                                                                                                                                                   |  |  | 13d INSIDE CITY LIMITS?                                             |  |  |
| Maryland                                                                                                                                                                                                                                                                                                            |  |  | Montgomery                                                                                                                |  |  | Olney                                                                                                                                                              |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14 FATHER'S NAME                                                                                                                                                                                                                                                                                                    |  |  | 15 MOTHER'S MAIDEN NAME                                                                                                   |  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                   |  |  | 16b SOCIAL SECURITY NO.                                             |  |  |
| George Pohle                                                                                                                                                                                                                                                                                                        |  |  | Sophia Hendrich                                                                                                           |  |  | No                                                                                                                                                                 |  |  | 077-14-1917A                                                        |  |  |
| 17 INFORMANT                                                                                                                                                                                                                                                                                                        |  |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): |  |  | 19                                                                                                                                                                 |  |  | #13                                                                 |  |  |
| Wilhelmina J.S. Van Hemert same as                                                                                                                                                                                                                                                                                  |  |  | 4408                                                                                                                      |  |  | DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC VASCULAR DISEASE                                                                                              |  |  |                                                                     |  |  |
|                                                                                                                                                                                                                                                                                                                     |  |  | DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                        |  |  |                                                                                                                                                                    |  |  |                                                                     |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                 |  |  |                                                                                                                           |  |  |                                                                                                                                                                    |  |  |                                                                     |  |  |
| CHRONIC BRAIN SYNDROME                                                                                                                                                                                                                                                                                              |  |  |                                                                                                                           |  |  |                                                                                                                                                                    |  |  |                                                                     |  |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                               |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                          |  |  | 20a AUTOPSY?                                                                                                                                                       |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |
|                                                                                                                                                                                                                                                                                                                     |  |  |                                                                                                                           |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF INJURY, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                   |  |  | 21b. TIME OF INJURY                                                                                                       |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                     |  |  |                                                                     |  |  |
|                                                                                                                                                                                                                                                                                                                     |  |  | HOUR A.M. MONTH DAY YEAR                                                                                                  |  |  |                                                                                                                                                                    |  |  |                                                                     |  |  |
|                                                                                                                                                                                                                                                                                                                     |  |  | P.M. 19                                                                                                                   |  |  |                                                                                                                                                                    |  |  |                                                                     |  |  |
| 21d INJURY OCCURRED                                                                                                                                                                                                                                                                                                 |  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                        |  |  | 21f LOCATION                                                                                                                                                       |  |  |                                                                     |  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                   |  |  |                                                                                                                           |  |  | STREET CITY OR TOWN COUNTY STATE                                                                                                                                   |  |  |                                                                     |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 16, 1983, to JUL 5, 1983, that (I) (we) last saw the deceased alive on JUL 5, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. |  |  |                                                                                                                           |  |  |                                                                                                                                                                    |  |  |                                                                     |  |  |
| 22b SIGNATURE                                                                                                                                                                                                                                                                                                       |  |  | DEGREE                                                                                                                    |  |  | 22c DATE SIGNED                                                                                                                                                    |  |  |                                                                     |  |  |
| Bernard A Fitzgerald MD                                                                                                                                                                                                                                                                                             |  |  |                                                                                                                           |  |  | 10-5-83                                                                                                                                                            |  |  |                                                                     |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                |  |  | 22e ADDRESS                                                                                                               |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                         |  |  |                                                                     |  |  |
| BERNARD A. FITZGERALD                                                                                                                                                                                                                                                                                               |  |  | 217 UNIVERSITY BLVD EAST, SILVER SPRING MD                                                                                |  |  |                                                                                                                                                                    |  |  |                                                                     |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                            |  |  | 23b DATE                                                                                                                  |  |  | 23c NAME OF CEMETERY OR CREMATORY                                                                                                                                  |  |  | 23d LOCATION CITY OR TOWN COUNTY STATE                              |  |  |
| Cremation                                                                                                                                                                                                                                                                                                           |  |  | Oct. 6, 1983                                                                                                              |  |  | Metropolitan Crem. Alexandria, Virginia                                                                                                                            |  |  | 20901                                                               |  |  |
| 24 FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                            |  |  | 25a DATE REC'D. BY REGISTRAR                                                                                              |  |  | 25b REGISTRAR'S SIGNATURE                                                                                                                                          |  |  |                                                                     |  |  |
| Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814                                                                                                                                                                                                                                                     |  |  | OCT 11 1983                                                                                                               |  |  | John J. Smith                                                                                                                                                      |  |  |                                                                     |  |  |

Chlorophyll *a* and *b*  
Fluorescence Spectroscopy

Chlorophyll *a* and *b*

10-2-01 10-2-01 10-2-01

10-2-01

Chlorophyll *a* and *b*

10-2-01 10-2-01 10-2-01

Chlorophyll *a* and *b*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

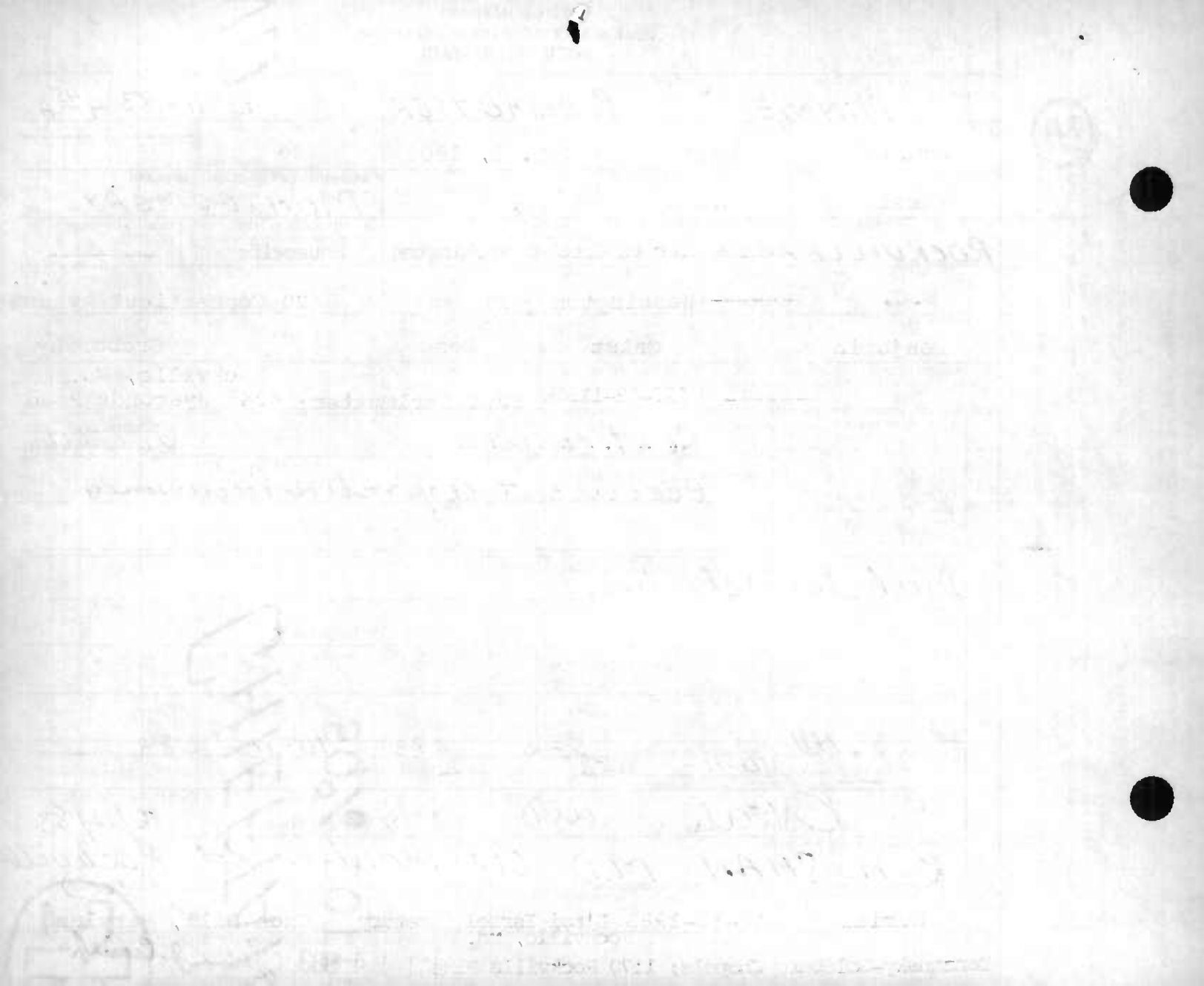
REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                        |  |                                                                                                                                                                                                                                                                                                         |                                                        |                                                                                                                                                             |                              |                                                                                                 |  |
|------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MINNIE PERLMUTTER</b>           |  |                                                                                                                                                                                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10-11-83</b> |                                                                                                                                                             | 2b. HOUR<br><b>4:45 A.M.</b> |                                                                                                 |  |
| 3. SEX<br><b>Female</b>                                                |  | 4. RACE<br><b>White</b>                                                                                                                                                                                                                                                                                 |                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 1, 1903</b>                                                                                                   |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Russia</b>             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                              |                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>ROCKVILLE</b>                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Hebrew Home of Greater Washington</b>                                                                                                                                                   |                                                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                                                        |                              | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |  |
| 13a. STATE<br><b>D.C.</b>                                              |  | 13b. COUNTY<br><b>Washington</b>                                                                                                                                                                                                                                                                        |                                                        | 13c. CITY OR TOWN<br><b>Washington</b>                                                                                                                      |                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Benjamin Galst</b>        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rose Grabarsky</b>                                                                                                                                                                                                                                  |                                                        | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>                                                                              |                              | 16b. SOCIAL SECURITY NO.<br><b>113-12-1158A</b>                                                 |  |
| 17. INFORMANT<br>ADDRESS<br><b>Saul Perlmutter; 4945 Wyaconda Road</b> |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>5070 IMMEDIATE CAUSE (a) Septicemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Recurrent Aspiration Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes Mellitus</b> |                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 months</b>                                                                                             |                              |                                                                                                 |  |

## MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                       |  |                                                                                                                                            |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                                                            |  |
| 22a. I certify that (this hospital) attended the deceased from <b>5-2</b> , 19 <b>83</b> , to <b>10-11</b> , 19 <b>83</b> , that (we) lost<br>saw the deceased alive on <b>10-11-83</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated<br>above, (I <del>have</del> <del>did not</del> view the body after death. |  |                                                                       |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>K. H. SHAH</b>                                                                                                                                                                                                                                                                                                                                         |  | DEGREE<br><b>M.D.</b>                                                 |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10/11/83</b>                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>K. H. SHAH</b>                                                                                                                                                                                                                                                                                                                  |  | 22e. ADDRESS<br><b>6121 Montrose Rd. Rockville</b>                    |  |                                                                                                                                            |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><b>10-13-1983</b>                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>B'nai Israel Cemetery</b>                                                                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Oxon Hill, Maryland</b>                                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>                                                                                                                                                                                                                                                                                      |  | ADDRESS<br><b>Rockville, Md.</b>                                      |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1983</b>                                                                                        |  | REGISTRAR'S SIGNATURE<br><b>John J. [Signature]</b>                                                                        |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 8 0 8

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|                                                                             |                                                                                                                                           |                                                                                                                                                             |                                                                                                     |                                                              |
|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HENNING</b> <b>E</b> <b>PETERSEN</b> |                                                                                                                                           | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10 12 83</b>                                                                                                         |                                                                                                     | 2b. HOUR<br><b>8 1/4</b> M                                   |
| 3. SEX<br><b>Male</b>                                                       | 4. RACE<br><b>Caucasian</b>                                                                                                               | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>July 30 1917</b>                                                                                                      |                                                                                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Denmark</b>                 | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Mont. Co.</b> MD. |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Wash. Adventist Hosp.</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Sheet Metal Worker-</b> | 12b. KIND OF BUSINESS OR INDUSTRY                            |

|                                                                                         |                                                                        |                                                                                                 |  |                                                               |
|-----------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |                                                                        | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>750-Fal rview Ave.</b> <b>20912</b> |
| 13a. STATE<br><b>Md.</b>                                                                | 13b. COUNTY<br><b>Montgomery</b>                                       | 13c. CITY OR TOWN<br><b>Takoma Park</b>                                                         |  |                                                               |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Albert C. Petersen</b>                        |                                                                        | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Sigrid Petersen</b>                            |  |                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>      | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII</b> | 17. INFORMANT ADDRESS<br><b>Charlotte E. Alvino - above address</b>                             |  |                                                               |

|                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cachexia</b><br><b>1579</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Carcinoma of pancreas with metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>4 months</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

|                                            |  |                                                                                                     |  |                                                                                      |                                                                                                                            |
|--------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION<br><b>Pneumonia</b> |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Dehydration Post Cholelithic jejunostomy</b> |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
|--------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                          |                                                                        |                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |

22a. I certify that (I) (this hospital) attended the deceased from **10/19**, 19 **83**, to **10/11**, 19 **83**, that (I) (we) last saw the deceased alive on **10/12**, 19 **83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

|                                                                    |                                                             |                                     |
|--------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------|
| 22b. SIGNATURE<br><b>Tungji Lee</b>                                | DEGREE                                                      | 22c. DATE SIGNED<br><b>10/12/83</b> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Tungji P. Lee M.D.</b> | 22e. ADDRESS<br><b>1411 Riggs Rd. Hyattsville, Md 20783</b> |                                     |

|                                                            |                                |                                                                                         |               |
|------------------------------------------------------------|--------------------------------|-----------------------------------------------------------------------------------------|---------------|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b> | 23b. DATE<br><b>10/14/1983</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Maryland Vet. Cem. Cheltenham Pr. Geo. Md.</b> | 23d. LOCATION |
|------------------------------------------------------------|--------------------------------|-----------------------------------------------------------------------------------------|---------------|

|                                                        |                                                    |                                                    |
|--------------------------------------------------------|----------------------------------------------------|----------------------------------------------------|
| 24. FUNERAL DIRECTOR NAME<br><b>Nalley's F.H. Inc.</b> | 25. DATE REC'D. BY REGISTRAR<br><b>OCT 18 1983</b> | 26. REGISTRAR'S SIGNATURE<br><b>John J. Gurnea</b> |
|--------------------------------------------------------|----------------------------------------------------|----------------------------------------------------|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SECRET

SECRET

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/82  
(VRA 15, 4)

|                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                |  |                                                                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                            |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                           |  | 8 2 27 8 0 9                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                     |  | FIRST MIDDLE LAST                                                                                                              |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                        |  |
| Robert L. Phillips                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                |  | 10 16 83                                                                                                                |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE                                                                                                                        |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                         |  |
| Male                                                                                                                                                                                                                                                                                                                                    |  | Caucasian                                                                                                                      |  | January 4, 1906                                                                                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                         |  |
| Maryland                                                                                                                                                                                                                                                                                                                                |  | United States                                                                                                                  |  | 77 YRS.                                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                    |  |
| Silver Spring                                                                                                                                                                                                                                                                                                                           |  | Holy Cross Hospital                                                                                                            |  | Montgomery County, MD.                                                                                                  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                                                                                                                                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                              |  | 13. STREET ADDRESS                                                                                                      |  |
| Painter                                                                                                                                                                                                                                                                                                                                 |  | House Painting                                                                                                                 |  | 3225 Blueford Rd. (zip 20895)                                                                                           |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                                                     |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                       |  |
| Andrew J. Phillips                                                                                                                                                                                                                                                                                                                      |  | Cora Hurley                                                                                                                    |  | No                                                                                                                      |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                                           |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 0389 |  | 19. DATE OF OPERATION                                                                                                   |  |
| E. Ann Wilkinson                                                                                                                                                                                                                                                                                                                        |  | Respiratory Failure                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                        |  |
| Niece, Same as item #13                                                                                                                                                                                                                                                                                                                 |  | DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis - Chronic Lung Disease                                                               |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
|                                                                                                                                                                                                                                                                                                                                         |  | DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                             |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 12 Hour - years                                                                                                                                                                                        |  |                                                                                                                                |  |                                                                                                                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                      |  |                                                                                                                                |  |                                                                                                                         |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                                                                                                                                                                                                                    |  |                                                                                                                                |  |                                                                                                                         |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                                                                                                                                                                                                                                                          |  |                                                                                                                                |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                  |  |                                                                                                                                |  |                                                                                                                         |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                     |  |                                                                                                                                |  |                                                                                                                         |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                          |  |                                                                                                                                |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from September 23, 1983, to October 16, 1983, and that (I) (we) last saw the deceased alive on October 16, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If any) (did) (did not) view the body after death. |  |                                                                                                                                |  |                                                                                                                         |  |
| 22b. SIGNATURE DEGREE                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                |  |                                                                                                                         |  |
| 22c. DATE SIGNED                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                |  |                                                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ADDRESS                                                                                                                                                                                                                                                                                           |  |                                                                                                                                |  |                                                                                                                         |  |
| Robert A. Pumphrey, MD 3700 Faints Ave. New Rd. 20855                                                                                                                                                                                                                                                                                   |  |                                                                                                                                |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                                                                                                                                          |  |                                                                                                                                |  |                                                                                                                         |  |
| Burial 21, 1983 Parklawn Memorial Park Rockville Maryland                                                                                                                                                                                                                                                                               |  |                                                                                                                                |  |                                                                                                                         |  |
| 24. FUNERAL DIRECTOR NAME 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                      |  |                                                                                                                                |  |                                                                                                                         |  |
| Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland OCT 25 1983 John J. Conner                                                                                                                                                                                                                                                   |  |                                                                                                                                |  |                                                                                                                         |  |



*[Faint, illegible text, likely bleed-through from the reverse side of the page. The text appears to be organized into a table or list format with multiple columns.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 8 1 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                            |  |                                                                       |                                                                                                                                             |                                                                                                                                                             |                             |  |
|--------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ROBERT ARNSON PHILIPSON</b> |  |                                                                       | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 18, 1983</b>                                                                              |                                                                                                                                                             | 2b. HOUR<br><b>1:45p.m.</b> |  |
| 3. SEX<br><b>Male</b>                                                                      |  | 4. RACE<br><b>White</b>                                               |                                                                                                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 14, 1898</b>                                                                                                  |                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                         |                                                                                                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>                                               |  |                                                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FERNWOOD NURSING CENTER</b> |                                                                                                                                                             |                             |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>C.P.A.</b>          |  |                                                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>ACCOUNTING FIRM</b>                                                                                 |                                                                                                                                                             |                             |  |
| 13a. STATE<br><b>D.C.</b>                                                                  |  |                                                                       | 13b. COUNTY<br><b>Washington</b>                                                                                                            |                                                                                                                                                             |                             |  |
| 13c. CITY OR TOWN<br><b>Washington</b>                                                     |  |                                                                       | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>                               |                                                                                                                                                             |                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HENRY PHILIPSON</b>                           |  |                                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ROSE (UNKNOWN)</b>                                                                      |                                                                                                                                                             |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>         |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWI</b> |                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>BRUCE PHILIPSON; 7004 MARBURY RD.; BETHESDA, MD 20817</b>                                                                    |                             |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

4340

IMMEDIATE CAUSE (a) **CEREBRAL THROMBOSIS**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **GENERALIZED ARTERIOSCLEROSIS**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

3 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

**Myocardial Infarction**

|                                                                                                                                                                                                                                                                                                                                         |  |                                                                        |  |                                                                                                    |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>Nov 1979</b> to <b>Oct 18, 1983</b> , that (1) (we) last saw the deceased alive on <b>Oct 17, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                    |  |
| 22b. SIGNATURE<br><b>Marvin Fuchs</b>                                                                                                                                                                                                                                                                                                   |  | DEGREE                                                                 |  | 22c. DATE SIGNED<br><b>Oct 18, 1983</b>                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARVIN FUCHS MD</b>                                                                                                                                                                                                                                                                         |  | 22e. ADDRESS<br><b>5315 Connecticut Ave NW Dc</b>                      |  |                                                                                                    |  |

|                                                                                                                                       |  |                                                    |  |                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                         |  | 23b. DATE<br><b>10/21/83</b>                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wash. Hebrew Cong. Mem. Pk.; Washington, D.C.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS<br/>1170 Rockville Pike; Rockville, Maryland 20852</b> |  | 25. DATE REC'D. BY REGISTRAR<br><b>OCT 21 1983</b> |  |                                                                                            |  |
| 26. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>                                                                                    |  |                                                    |  |                                                                                            |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 27811

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|                                                                                                               |                                                                                                                                         |                                                                                                                                                             |                                                                                                 |                                                                                               |                                           |
|---------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Mary A Piersma</i>                                                     |                                                                                                                                         |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>Oct 21, 1983</i>                                         |                                                                                               | 2b. HOUR<br><i>5:50 AM</i>                |
| 3. SEX<br><b>FEMALE</b>                                                                                       | 4. RACE<br><b>WHITE</b>                                                                                                                 | 5. DATE OF BIRTH<br><b>SEPTEMBER 4, 1941</b>                                                                                                                |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>42</b>                                                  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>TEXAS</b>                                                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery County, MD</i>                          |                                           |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Ably Cross Hospital</i> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TEACHER</b>              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PRIVATE SCHOOL</b>                                    |                                           |
| 13a. STATE<br><b>MARYLAND</b>                                                                                 | 13b. COUNTY<br><b>MONTGOMERY</b>                                                                                                        | 13c. CITY OR TOWN<br><b>SILVER SPRING</b>                                                                                                                   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>1308 CANYON RD., 20904</b>                                          |                                           |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>BLANCHARD COOPER</b>                                             |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>NORMADENE MODESETT</b>                                                                                  |                                                                                                 |                                                                                               |                                           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b> |                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br><b>213-40-7435</b>                                                                                                              |                                                                                                 | 17. INFORMANT ADDRESS<br><b>ROBERT PIER SMA, HUSBAND, 1308 CANYON RD., SILVER SPRING, MD.</b> |                                           |

|                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <i>Myocardial Infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>immediate</i><br><b>1 yr.</b> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

|                                                                                                                                                                                                                                                                                                                                                                             |                                                                        |                                                                                |                                                                                                                                               |                                                                           |                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                      |                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                               |                                                                                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                                                                                                                               |                                                                           |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                                               |                                                                           |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10-19</i> , 19 <i>83</i> , to <i>10-21</i> , 19 <i>83</i> , that (I) (we) lost<br>saw the deceased alive on <i>10-20</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |                                                                        |                                                                                |                                                                                                                                               |                                                                           |                                                                                                                            |
| 22b. SIGNATURE<br><i>Frederick G. Barr</i>                                                                                                                                                                                                                                                                                                                                  |                                                                        | DEGREE<br><i>M.D.</i>                                                          | ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN DIRECTOR PHYSICIAN |                                                                           | 22c. DATE SIGNED<br><b>10/22/83</b>                                                                                        |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>FREDERICK G. BARR M.D.</b>                                                                                                                                                                                                                                                                                                      |                                                                        | 22e. ADDRESS<br><b>106 IRVING ST., N.W., WASH., D.C.</b>                       |                                                                                                                                               |                                                                           |                                                                                                                            |

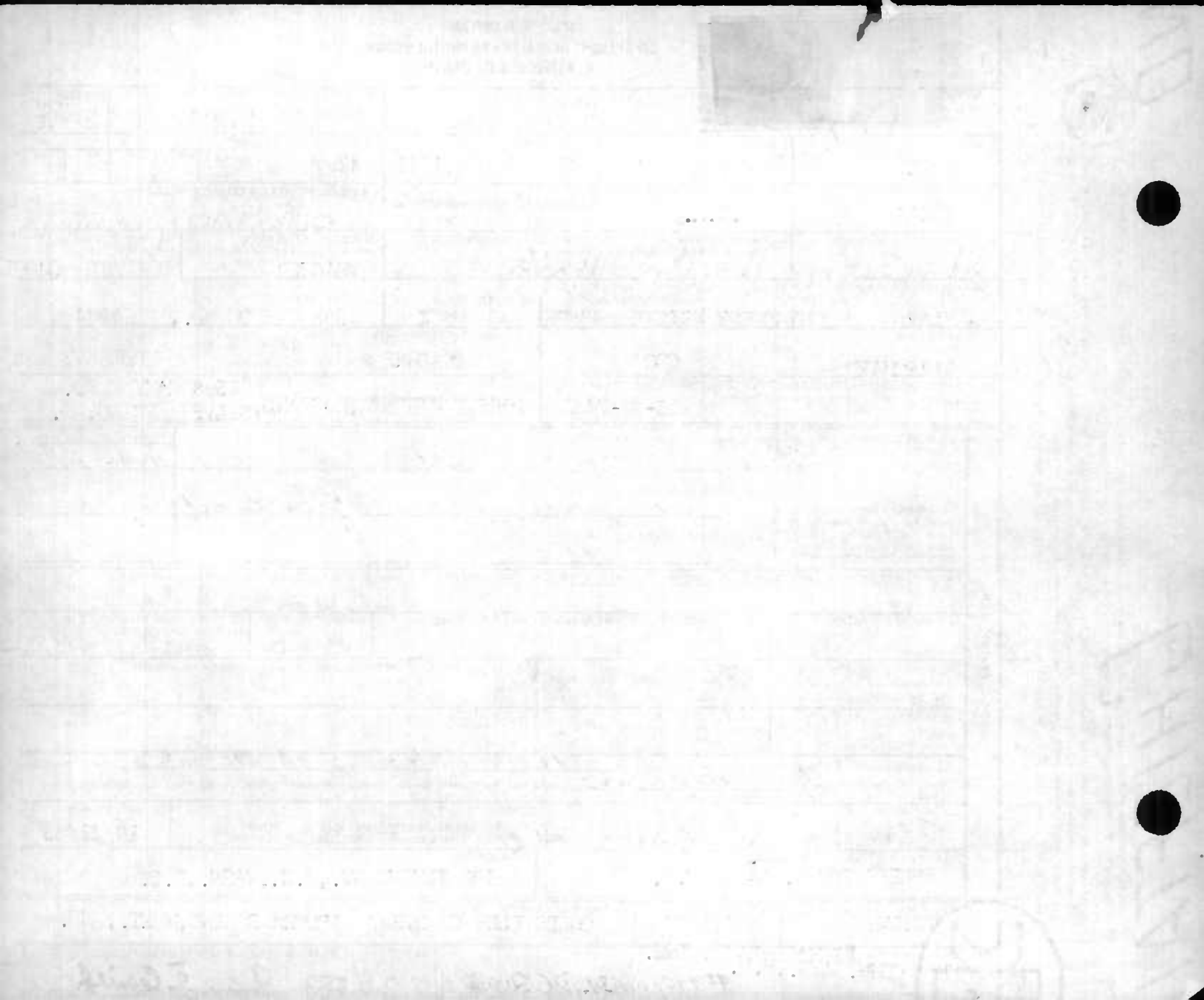
|                                                               |                              |                                                                  |                                                   |
|---------------------------------------------------------------|------------------------------|------------------------------------------------------------------|---------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b> | 23b. DATE<br><b>10/24/83</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>COLESVILLE CEMETERY</b> | 23d. LOCATION<br><b>SILVER SPRING, MONT., MD.</b> |
|---------------------------------------------------------------|------------------------------|------------------------------------------------------------------|---------------------------------------------------|

|                                                   |                                                     |                                                     |
|---------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------|
| 24. FUNERAL DIRECTOR<br><b>RICHARD RAPP, INC.</b> | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 26 1983</b> | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i> |
|---------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------|

1120 CONN. AVE., N.W.

#940, WASH. DC 20036





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                  |                                                                                                                               | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                |                                                                                                 | 8 3 2 7 8 1 2                                                                        |                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------|
| Howard Samuel Piquet                                                                                                                                                                                                                                                                                                                                    |                                                                                                                               | CERTIFICATE OF DEATH                                                                                                                                        |                                                                                                 | REG. NO.                                                                             |                                                 |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Howard Samuel Piquet                                                                                                                                                                                                                                                                        |                                                                                                                               |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10-31-83<br>2b. HOUR<br>11:43 P.M.                       |                                                                                      |                                                 |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                          | 4. RACE<br>W.H.T.e                                                                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 4, 1903                                                                                                          |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80<br>IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NY                                                                                                                                                                                                                                                                                                         | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD                                |                                                 |
| 10. CITY OR TOWN OF DEATH<br>TAKOMA                                                                                                                                                                                                                                                                                                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>WASH. ADV. HOSP. |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ECONOMIST                   |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. GOVT. |
| 13a. STATE<br>DC 20012                                                                                                                                                                                                                                                                                                                                  | 13b. COUNTY<br>NONE                                                                                                           | 13c. CITY OR TOWN<br>WASHINGTON                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>2045 Yorktown Rd. N.W.                                        |                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>SAMUEL PIQUET                                                                                                                                                                                                                                                                                                 |                                                                                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LAURA MANN                                                                                                 |                                                                                                 |                                                                                      |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                              |                                                                                                                               | 16b. SOCIAL SECURITY NO.<br>579-44-7442                                                                                                                     |                                                                                                 | 17. INFORMANT<br>DOROTHY B. PIQUET SAME AS #13                                       |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4029 IMMEDIATE CAUSE (a). CARDIAC ARREST<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) HYPERTENSIVE AND ARTERIO SCLEROTIC HEART DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                                                                                                               |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>PNEUMONIA, CORONARY VASCULAR OCCLUSION AND MEMORABAGE                                                                                                                                                            |                                                                                                                               |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                  |                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                 |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                              |                                                                                                                               | 21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                               |                                                                                                 |                                                                                      |                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                |                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                                 | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                            |                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from 1983, to OCT 31, 1983, that (I) (we) lost saw the deceased alive on OCT 31, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                           |                                                                                                                               |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                 |
| 22b. SIGNATURE<br>Robert L. Krichmar                                                                                                                                                                                                                                                                                                                    |                                                                                                                               | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |                                                                                                 | 22c. DATE SIGNED<br>NOV 1 1983                                                       |                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROBERT L. KRICHMAR                                                                                                                                                                                                                                                                                             |                                                                                                                               | 22e. ADDRESS<br>7733 BRASKA AVENUE N.W.<br>WASHINGTON D.C. 20012                                                                                            |                                                                                                 |                                                                                      |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>CREMATION                                                                                                                                                                                                                                                                                                  |                                                                                                                               | 23b. DATE<br>11/2/83                                                                                                                                        |                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br>CEDAR HILL CROM.                               |                                                 |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SUITLAND, MD                                                                                                                                                                                                                                                                                              |                                                                                                                               | 24. FUNERAL DIRECTOR<br>NAME Joseph Gawler's Sons, Inc.<br>5130 Wisc. Ave. N.W. Wash., D.C. 20016                                                           |                                                                                                 |                                                                                      |                                                 |
| 25. DATE REC'D. BY REGISTRAR<br>8 1983                                                                                                                                                                                                                                                                                                                  |                                                                                                                               | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel                                                                                                                |                                                                                                 |                                                                                      |                                                 |

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BUREAU OF PLANT INDUSTRY  
WASHINGTON, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrator, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                 |  |                                                                                                                                |  |                                                                                                                                                                |  |                                                                                      |  |                                                                                                                               |                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                         |  | REG. NO. 83 27813                                                                                                              |  |                                                                                                                                                                |  |                                                                                      |  |                                                                                                                               |                                                                               |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John McNeil Plank, Sr.                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                |  |                                                                                                                                                                |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Oct 01 1983                                   |  | 2b. HOUR<br>2:40P M                                                                                                           |                                                                               |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br>White                                                                                                               |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct 15 1902                                                                                                              |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br>80 YRS                                         |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |                                                                               |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN)<br>Kentucky                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                         |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                               |  |                                                                                                                               |                                                                               |
| 10. CITY OR TOWN OF DEATH<br>Bethesda                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  |                                                                                                                                                                |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>District Manager |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Drug Store                                                                               |                                                                               |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md. 20816                                                                                                                                                                                                                                              |  |                                                                                                                                |  |                                                                                                                                                                |  | 13b. COUNTY<br>Montgomery                                                            |  | 13c. CITY OR TOWN<br>Bethesda                                                                                                 |                                                                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Newton Wyatt Plank                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                |  |                                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Allie Neff                          |  |                                                                                                                               |                                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>223-01-7758                                                         |  | 17. INFORMANT<br>ADDRESS<br>John M. Plank, 1324 Catonsville, Md.<br>Lincoln Woods Drive,                                                                       |  |                                                                                      |  |                                                                                                                               |                                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arterio-sclerotic heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Generalized Atherosclerosis</u>                                                   |  |                                                                                                                                |  |                                                                                                                                                                |  |                                                                                      |  |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>2 hrs<br>1-4 yrs<br>20 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)                                                                                                                                                                                                                                 |  |                                                                                                                                |  |                                                                                                                                                                |  |                                                                                      |  |                                                                                                                               |                                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                               |  |                                                                                                                                                                |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                 |  |                                                                                      |  |                                                                                                                               |                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                      |  |                                                                                                                               |                                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>50</u> , to <u>Oct</u> , 19 <u>83</u> , that (I) (we) lost<br>saw the deceased alive on <u>1 Oct</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (we did not) view the body after death. |  |                                                                                                                                |  |                                                                                                                                                                |  |                                                                                      |  |                                                                                                                               |                                                                               |
| 22b. SIGNATURE<br><u>John M. Wyman MD</u>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                |  | DEGREE<br><u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                                                                                      |  | 22c. DATE SIGNED<br>10/1/83                                                                                                   |                                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOHN M WYMAN MD                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                |  | 22e. ADDRESS<br>7801 Norfolk Ave Bethesda Md 20814                                                                                                             |  |                                                                                      |  |                                                                                                                               |                                                                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br>10/4/1983                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br>National Memorial Park Cem.                                                                                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Falls Church Virginia                  |  |                                                                                                                               |                                                                               |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph Gawler's Sons Inc.<br>5130 Wisc. Ave., N.W. Washington, D.C.                                                                                                                                                                                                                                                                  |  |                                                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 6 1983                                                                                                                    |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Gaird                                          |  |                                                                                                                               |                                                                               |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 472 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

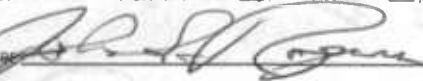

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                    |                                                     |                                                                                                                                                             |                                |                                                                                                 |  |                                                                                                                     |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Emma M. Porter</b>                                                                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                    |                                                     |                                                                                                                                                             |                                | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>Oct 23, 1983</b>                                        |  | 2b. HOUR <b>1:15</b>                                                                                                |                                              |
| 3. SEX <b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                                        | 4. RACE <b>W</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>March 28, 1920</b>                                                                           | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>63</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS                                                                                                                               | IF UNDER 24 HRS.<br>HOURS MIN. | 7c. DATE PRONOUNCED DEAD <b>Oct 23, 1983</b>                                                    |  | 7d. HOUR <b>1:15</b>                                                                                                |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Rhode Island</b>                                                                                                                                                                                                                                                                                                                                                                       |                  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                      |                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD                                    |  |                                                                                                                     |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>                                                                                                                                                                                                                                                                                                                                                                                           |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hosp</b> |                                                     |                                                                                                                                                             |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>US Gov't.</b>                                                               |                                              |
| 13a. STATE <b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 13b. COUNTY <b>Mont</b>                                                                                                            |                                                     | 13c. CITY OR TOWN <b>Bethesda</b>                                                                                                                           |                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>20816 5019 Newport Ave</b>                                                                |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles -- Meservy</b>                                                                                                                                                                                                                                                                                                                                                                    |                  |                                                                                                                                    |                                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helen -- Brennan</b>                                                                                    |                                |                                                                                                 |  |                                                                                                                     |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                     |                  | 16b. SOCIAL SECURITY NO.<br><b>039-03-9705</b>                                                                                     |                                                     | 17. INFORMANT ADDRESS<br><b>John F. Porter, Same address as #13.</b>                                                                                        |                                |                                                                                                 |  |                                                                                                                     |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>4291<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF                                                              |                  |                                                                                                                                    |                                                     |                                                                                                                                                             |                                |                                                                                                 |  |                                                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1<br><b>None</b>                                                                                                                                                                                                                                                                                          |                  |                                                                                                                                    |                                                     |                                                                                                                                                             |                                |                                                                                                 |  |                                                                                                                     |                                              |
| 19a. DATE OF OPERATION<br><b>None</b>                                                                                                                                                                                                                                                                                                                                                                                                  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                  |                                                     |                                                                                                                                                             |                                |                                                                                                 |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |                                              |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                         |                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                |                                                                                                 |  |                                                                                                                     |                                              |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                 |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC)                                                                         |                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                |                                                                                                 |  |                                                                                                                     |                                              |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                  |                                                                                                                                    |                                                     |                                                                                                                                                             |                                |                                                                                                 |  |                                                                                                                     |                                              |
| ACTUAL SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                |                  | TITLE (SPECIFY)<br><b>M.D. Dep.</b>                                                                                                |                                                     | MEDICAL EXAMINER                                                                                                                                            |                                |                                                                                                 |  | DATE SIGNED<br><b>Oct 23, 1983</b>                                                                                  |                                              |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>John S. Rogers</b>                                                                                                                                                                                                                                                                                                                                                                            |                  | ADDRESS<br><b>Silver Spring, Montgomery Co., Md.</b>                                                                               |                                                     |                                                                                                                                                             |                                |                                                                                                 |  |                                                                                                                     |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                             |                  | 23b. DATE<br><b>10/27/83</b>                                                                                                       |                                                     | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>                                                                                            |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, D.C.</b>                           |  |                                                                                                                     |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph Gawler's Sons, Inc.</b>                                                                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                    |                                                     | ADDRESS<br><b>5130 Wisconsin Avenue, NW, Washington, D.C. 20016</b>                                                                                         |                                | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 27 1983</b>                                             |  | 25b. REGISTRAR'S SIGNATURE<br> |                                              |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                            |  |                                                                                                                                                  |  |                                                                                                                               |                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                          |  | FIRST MIDDLE LAST<br>AILEEN Bell POSTON                                                                                    |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 31 83                                                                                                     |  | 2b. HOUR<br>1:25 P M                                                                                                          |                                                 |
| 3. SEX<br>Female.                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br>White.                                                                                                          |  | 5. DATE OF BIRTH<br>August 13, 1901                                                                                                              |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82                                                                                         |                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>North Carolina.                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                                                                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montg. Co. MD.                                                                        |                                                 |
| 10. CITY OR TOWN OF DEATH<br>Kensington.                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(If none, give street address)<br>Kensington Gardens, Md.       |  | 12a. USUAL OCCUPATION<br>(If present, give address or work place)<br>Practical Nurse.                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                             |                                                 |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>Maryland. Montg.                                                                                                                                                                                                                                             |  | 13b. CITY OR TOWN INSIDE CITY LIMITS?<br>Silver Spring YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13. STREET ADDRESS<br>20910 Chesapeake Ave. S.S. Md.                                                                                             |  |                                                                                                                               |                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jacob Bell                                                                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Jeannie Street.                                                           |  |                                                                                                                                                  |  |                                                                                                                               |                                                 |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                          |  | 16a. SOCIAL SECURITY NO.<br>243-34-6148                                                                                    |  | 17. INFORMANT ADDRESS<br>Daughter- Frances Zynda.13 e                                                                                            |  |                                                                                                                               |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic heart disease.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>arterial infarction</u>                                 |  |                                                                                                                            |  |                                                                                                                                                  |  |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ( )                                                                                                                                                                                                                         |  |                                                                                                                            |  |                                                                                                                                                  |  |                                                                                                                               |                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                           |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                    |  |                                                                                                                               |                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                |  |                                                                                                                               |                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/31</u> 19 <u>83</u> , to <u>10/31</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>10/27</u> 19 <u>83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                            |  |                                                                                                                                                  |  |                                                                                                                               |                                                 |
| 27b. SIGNATURE<br>Tony P. Kannerkat MD                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                            |  | DEGREE<br>MD                                                                                                                                     |  | 27c. DATE SIGNED<br>10/31/83                                                                                                  |                                                 |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>TONY P. KANNERKAT, MD.                                                                                                                                                                                                                                                                                              |  |                                                                                                                            |  | 27e. ADDRESS<br>8201 16th St. S.S. MD 20910                                                                                                      |  |                                                                                                                               |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br>Nov. 2, 1983                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Ft. Lincoln                                                                                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Bladesburg Rd. P. G. Md.                                                        |                                                 |
| 24. FUNERAL DIRECTOR<br>(Signature)                                                                                                                                                                                                                                                                                                                          |  | Takoma Funeral Home<br>ADDRESS<br>254 Carroll St. N. W. D. C.                                                              |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 02 1983                                                                                                     |  | 25b. REGISTRAR'S SIGNATURE<br>J. E. C. C.                                                                                     |                                                 |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial or cremation.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8327816

|                                                                                                                                                                                                                                                                     |  |                                                                                                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                              |  | REG. NO.                                                                                                                        |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>SUE AILEEN PRANULIS                                                                                                                                                                                                             |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>OCTOBER 22, 1983                                                                            |  |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                    |  | 2b. HOUR<br>3:45 a.m.                                                                                                           |  |
| 4. RACE<br>WHITE                                                                                                                                                                                                                                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.                                                                                      |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br>MARCH 3, 1924                                                                                                                                                                                                                    |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>PENNSYLVANIA                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                             |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY COUNTY, MD.                                                                  |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CLINICAL CENTER (NIH) |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Beautician                                                                                                                                                                                         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>--                                                                                         |  |
| 13a. USUAL RESIDENCE 1 IF NURSING HOME OR OTHER INSTITUTION; GIVE RESIDENCE BEFORE ADMISSION<br>13a. STATE<br>PENNSYLVANIA                                                                                                                                          |  | 13b. CITY OR TOWN<br>BUTLER                                                                                                     |  |
| 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                |  | 13d. STREET ADDRESS<br>228 ISLE ROAD                                                                                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Charles H. Bauman                                                                                                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Martha Heck                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br>no                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.<br>196-16-8658                                                                                         |  |
| 17. INFORMANT<br>MR. BERNARD PRANULIS (HUSBAND)                                                                                                                                                                                                                     |  | ADDRESS SAME AS ABOVE                                                                                                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                                                                                                                                                            |  |                                                                                                                                 |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac Failure<br>3940<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c)            |  |                                                                                                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                 |  |                                                                                                                                 |  |
| 19a. DATE OF OPERATION<br>10/21/83                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Mitral Stenosis: ASD: Tricuspid Dis.                                        |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                         |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                      |  | 21d. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                 |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from OCT. 16, 1983, to OCT. 22, 1983, that (we) lost saw the deceased alive on above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |                                                                                                                                 |  |
| 22b. SIGNATURE<br>Jose Montalvo MD                                                                                                                                                                                                                                  |  | 22c. DATE SIGNED<br>10-22-83                                                                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jose Montalvo MD                                                                                                                                                                                                           |  | 22e. ADDRESS<br>NATIONAL INSTITUTES OF HEALTH<br>CLINICAL CENTER, BETHESDA, MD, 20205                                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                 |  | 23b. DATE<br>10-25-83                                                                                                           |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Greenlawn Burial Estates                                                                                                                                                                                                      |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Mt. Chestnut, Pa.                                                                    |  |
| 24. FUNERAL DIRECTOR<br>Marshall's Funeral Home<br>4217 9th St NW: Washington, D.C.                                                                                                                                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 26 1983                                                                                    |  |
| 25b. REGISTRAR'S SIGNATURE<br>John J. Connel                                                                                                                                                                                                                        |  |                                                                                                                                 |  |

RECEIVED  
JUN 10 1964  
U.S. AIR FORCE

CHIEFLIN



U.S. AIR FORCE  
JUN 10 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|----------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                    |  | REG. NO.                                                                                               |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                          |  |                                                                                                        |  | 2a. DATE OF DEATH                                                                                                                                        |  | MONTH                                                               |  | DAY                                                            |  |
| MARY M PRICE                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | OCTOBER 28                                                                                                                                               |  | 1983                                                                |  | 2:20A M                                                        |  |
| 3. SEX                                                                                                                                                                                                                                                                                                    |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. UNDER 1 YEAR                                                |  |
| FEMALE                                                                                                                                                                                                                                                                                                    |  | CAUCASIAN                                                                                              |  | JAN 24 1892                                                                                                                                              |  | 91 YRS.                                                             |  | MONTHS DAYS HOURS MIN                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                                                |  |
| NORTH CAROLINA                                                                                                                                                                                                                                                                                            |  | USA                                                                                                    |  |                                                                                                                                                          |  | MONTGOMERY MD                                                       |  |                                                                |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| SANDY SPRING                                                                                                                                                                                                                                                                                              |  | FRIENDS NURSING HOME                                                                                   |  |                                                                                                                                                          |  | Homemaker                                                           |  |                                                                |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                   |  | 13a. STATE                                                                                             |  | 13b. CITY OR TOWN                                                                                                                                        |  | 13c. INSIDE CITY LIMITS?                                            |  | 13d. STREET ADDRESS                                            |  |
| Maryland                                                                                                                                                                                                                                                                                                  |  | Montgomery                                                                                             |  | Silver Spring                                                                                                                                            |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20906 3435 S. Leisure World Blvd.                              |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME                                                                               |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                        |  | 16b. SOCIAL SECURITY NO                                             |  | 17. INFORMANT                                                  |  |
| JAMES                                                                                                                                                                                                                                                                                                     |  | ELIZABETH                                                                                              |  | NO                                                                                                                                                       |  | 050223629                                                           |  | Daughter Mary P. Lamonda                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                 |  | 19. IMMEDIATE CAUSE (a)                                                                                |  | 20. DUE TO, OR AS A CONSEQUENCE OF (b)                                                                                                                   |  | 21. DUE TO, OR AS A CONSEQUENCE OF (c)                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| 4140                                                                                                                                                                                                                                                                                                      |  | Cardiac arrest                                                                                         |  | Arteriosclerotic heart disease.                                                                                                                          |  |                                                                     |  | Sudden                                                         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                        |  | Prior strokes, decubiti, hypertension, arthritis, osteoporosis, compression fractures, diabetes        |  |                                                                                                                                                          |  |                                                                     |  | Sev. wounds.                                                   |  |
| 21a. DATE OF OPERATION                                                                                                                                                                                                                                                                                    |  | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  | 21d. AUTOPSY?                                                       |  | 21e. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                        |  | 21b. TIME OF INJURY                                                                                    |  | 21c. LOCATION                                                                                                                                            |  | 21d. PLACE OF INJURY                                                |  | 21e. CITY OR TOWN                                              |  |
|                                                                                                                                                                                                                                                                                                           |  | HOUR A.M. MONTH DAY YEAR                                                                               |  | STREET                                                                                                                                                   |  | AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                       |  | COUNTY STATE                                                   |  |
| 21a. INJURY OCCURRED                                                                                                                                                                                                                                                                                      |  | 21b. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                 |  | 21c. LOCATION                                                                                                                                            |  | 21d. PLACE OF INJURY                                                |  | 21e. CITY OR TOWN                                              |  |
|                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  | STREET                                                                                                                                                   |  | AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                       |  | COUNTY STATE                                                   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 19 72 to 28 Oct 19 83, that (I) (we) last saw the deceased alive on 26 Oct 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
| 22a. SIGNATURE                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  | 22b. ADDRESS                                                                                                                                             |  |                                                                     |  | 22c. DATE SIGNED                                               |  |
| Donald E. Dillen M.D.                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  | 811 Pr. Philip Dr Olney, Md 20832                                                                                                                        |  |                                                                     |  | 28 Oct 83                                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                     |  |                                                                                                        |  | 22e. ADDRESS                                                                                                                                             |  |                                                                     |  | 22f. DATE REC'D BY REGISTRAR                                   |  |
| Donald E. Dillen, M.D.                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  | 811 Pr. Philip Dr Olney, Md 20832                                                                                                                        |  |                                                                     |  | 28 Oct 83                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                 |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION                                                       |  | 23e. COUNTY                                                    |  |
| Burial                                                                                                                                                                                                                                                                                                    |  | Nov. 1 1983                                                                                            |  | Oakdale Cemetery                                                                                                                                         |  | Wilmington New Hanover N. C.                                        |  | STATE                                                          |  |
| 24. FUNERAL DIRECTOR'S NAME                                                                                                                                                                                                                                                                               |  |                                                                                                        |  | 24b. ADDRESS                                                                                                                                             |  |                                                                     |  | 24c. DATE REC'D BY REGISTRAR                                   |  |
| Francis J. Collins                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  | 500 University Blvd., W. Silver Spring, Md.                                                                                                              |  |                                                                     |  | 24d. REGISTRAR'S SIGNATURE                                     |  |
|                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  | NOV 2 1983                                                                                                                                               |  |                                                                     |  | John J. Caldwell                                               |  |

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*[Faint, illegible handwriting across the page, possibly a letter or document.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 410-326-7100.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                           |  |  |  |  |                                                                                                                                                             |  |  |                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                         |  |  |  |  | REG. NO.                                                                                                                                                    |  |  |                                                                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Kamakshamma Puranam</b>                                                                                                                                                                                                                                                                                 |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>October 15, 1983</b>                                                                                                 |  |  |                                                                     |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                        |  |  |  |  | 2b. HOUR<br><b>9:25 A.M.</b>                                                                                                                                |  |  |                                                                     |  |
| 4. RACE<br><b>Indian</b>                                                                                                                                                                                                                                                                                                                       |  |  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Jan 15, 1898</b>                                                                                                      |  |  |                                                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>India</b>                                                                                                                                                                                                                                                                                      |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.                                                                                                           |  |  |                                                                     |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br><b>India</b>                                                                                                                                                                                                                                                                                                   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>                                                                                                                                                                                                                                                                                                   |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                                                                                        |  |  |                                                                     |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b>                                                                                                                                                                                                          |  |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                                                        |  |  |                                                                     |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>                                                                                                                                                                                                                                                                                           |  |  |  |  |                                                                                                                                                             |  |  |                                                                     |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                  |  |  |  |  | 13b. COUNTY<br><b>Montgomery</b>                                                                                                                            |  |  |                                                                     |  |
| 13c. CITY OR TOWN<br><b>Rockville</b>                                                                                                                                                                                                                                                                                                          |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  |  |                                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Tallavajhala G. Sastry</b>                                                                                                                                                                                                                                                                        |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>n/a Konamma</b>                                                                                         |  |  |                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                              |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>214 94 5165</b>                                                                                                              |  |  |                                                                     |  |
| 17. INFORMANT<br>ADDRESS<br><b>J. Sri Ram (grandson) see #13</b>                                                                                                                                                                                                                                                                               |  |  |  |  |                                                                                                                                                             |  |  |                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ventricular tachycardia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>cardiomyopathy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>unknown</b>                                                         |  |  |  |  |                                                                                                                                                             |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>immediate</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)                                                                                                                                                                                                           |  |  |  |  |                                                                                                                                                             |  |  |                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                         |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |  |                                                                     |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                           |  |  |  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                               |  |  |                                                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                       |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>12 19 83</b>                                                                                          |  |  |                                                                     |  |
| 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                                                                                                                                                                                                              |  |  |  |  |                                                                                                                                                             |  |  |                                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                 |  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>12 19 83</b>                                                                   |  |  |                                                                     |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>12 19 83</b>                                                                                                                                                                                                                                                                           |  |  |  |  |                                                                                                                                                             |  |  |                                                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 12, 1983</b> to <b>Oct. 15, 1983</b> , that (I) (we) last saw the deceased alive on <b>Oct. 15, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death, so state.) |  |  |  |  |                                                                                                                                                             |  |  |                                                                     |  |
| 22b. SIGNATURE<br><b>Peter Pushkas, MD</b>                                                                                                                                                                                                                                                                                                     |  |  |  |  | 22c. DATE SIGNED<br><b>Oct. 15, 1983</b>                                                                                                                    |  |  |                                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Peter Pushkas, MD</b>                                                                                                                                                                                                                                                                              |  |  |  |  | 22e. ADDRESS<br><b>11510 Old Georgetown Rd., Rockville, Md</b>                                                                                              |  |  |                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                               |  |  |  |  | 23b. DATE<br><b>Oct. 16, 1983</b>                                                                                                                           |  |  |                                                                     |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>                                                                                                                                                                                                                                                                              |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland, P.G. Maryland</b>                                                                                |  |  |                                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland</b>                                                                                                                                                                                                                                       |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 19 1983</b>                                                                                                         |  |  |                                                                     |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                                                                                                                                                                                                                                                                                            |  |  |  |  |                                                                                                                                                             |  |  |                                                                     |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                              |  |                                                                                                                                          |  | REG. NO.                                                                                                                                                    |  |                                                                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                          |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                            |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>GEORGE ALBERT PURPLE</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                          |  | 2b. HOUR<br><b>7:25p M</b>                                                                                                                                  |  |                                                                                                                         |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>CAUCASIAN</b>                                                                                                              |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>DECEMBER 20 1920</b>                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><b>62</b>                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>CONNECTICUT</b>                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NAVAL HOSPITAL BETHESDA</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>U.S. NAVY</b>                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |
| 13a. STATE<br><b>CONNECTICUT</b>                                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY<br><b>NEW LONDON</b>                                                                                                         |  | 13c. CITY OR TOWN<br><b>NORWICH</b>                                                                                                                         |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>GEORGE ALBERT PURPLE</b>                                                                                                                                                                                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>DELIA MICHAUD</b>                                                                       |  | 13e. STREET ADDRESS<br><b>34 COUNTY FAIR RD.</b>                                                                                                            |  | 99999                                                                                                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.<br><b>1940-1962 042-18-5741</b>                                                                                 |  | 17. INFORMANT<br><b>AVEL PURPLE, 34 COUNTY FAIR RD., NORWICH,</b>                                                                                           |  | ADDRESS                                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ERYTHROLEUKEMIA</b><br><b>2070</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____            |  |                                                                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>SEPSIS</b>                                                                                                                                                                                                                             |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 26</b> , 19 <b>83</b> , to <b>OCTOBER 7</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>OCTOBER 7</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 22b. SIGNATURE <b>Michael D. Canty</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                          |  | DEGREE <b>M.D.</b>                                                                                                                                          |  | 22c. DATE SIGNED <b>8 Oct 83</b>                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MICHAEL D. CANTY, LT, MC, USNR</b>                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                          |  | 22e. ADDRESS<br><b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA MD. 20814</b>                                                   |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPEIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><b>Oct. 12, 1983</b>                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Joseph's Cemetery</b>                                                                                          |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Norwich, Conn.</b>                                                        |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Murphy Funeral Home</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                          |  | ADDRESS<br><b>Arlington, Va.</b>                                                                                                                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 17 1983</b>                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                          |  | REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                                                                                              |  |                                                                                                                         |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8327820

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                               |                                                            |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Josephine Pursell</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Oct. 3, 1983</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>12:45 PM</b>                                                                     |  |                                                                                                                            |  |
| SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br><b>white</b>                                                                                                                       |                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 13, 1892</b>                                                                                                 |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b>                                                    |  | 7b. HOUR<br>MONTHS DAYS HOURS MIN.<br><b>12 45 PM</b>                                                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Illinois</b>                                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                    |                                                            | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery MD.</b>                                   |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Collingswood Nursing Home</b> |                                                            |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                                                           |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 13b. COUNTY<br><b>Montgomery</b>                                                                                                              |                                                            | 13c. CITY OR TOWN<br><b>Silver Spring</b>                                                                                                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>8722 Colesville Road 20910</b>                                                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                               |                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>521 05 4223</b>                                                                 |                                                            | 17. INFORMANT<br>ADDRESS<br><b>Maryland 20906</b>                                                                                                           |  | <b>Sue B. VanVranken 3950 Ferrara Dr. Wheaton.</b>                                              |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR STROKE</b><br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CEREBROVASCULAR ARTERIOSCLEROSIS</b><br>10 YRS.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>GENERALIZED ARTERIOSCLEROSIS</b><br>20 YRS.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 DAYS</b> |  |                                                                                                                                               |                                                            |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>SENILE DEMENTIA 8 yrs</b>                                                                                                                                                                                                                                                           |  |                                                                                                                                               |                                                            |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br><b>2/9</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>2</b>                                                                                  |                                                            |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                                                                                  |                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>APR 16, 1971</b> to <b>OCT. 3, 1983</b> , that (1) (we) lost<br>saw the deceased alive on <b>SEPT. 26, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death.                                                                          |  |                                                                                                                                               |                                                            |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>John P. Nasou, MD</b>                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                               |                                                            | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>10-3-83</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John P. Nasou</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                               |                                                            | 22e. ADDRESS<br><b>800 Pershing Drive, Silver Spring, Md. 20910</b>                                                                                         |  |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br><b>10/4/83</b>                                                                                                                   |                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Memorial Park</b>                                                                                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rockville, Maryland</b>                        |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Tyson Wheeler Funeral Home, Inc.</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                               |                                                            | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 7 1983</b>                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                             |  |                                                                                                                            |  |

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                         |  |                                                                                                                                                    |                                                                           |                                                                                                                                                             |                                                                       |                                                                                      |                                                                                              |                                                                                                                                            |                                                                                                 |                                                  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                    |                                                                           |                                                                                                                                                             | REG. NO.                                                              |                                                                                      |                                                                                              |                                                                                                                                            |                                                                                                 |                                                  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ISRAEL RABINOVICH</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                    |                                                                           |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>OCTOBER, 27, 83</b>            |                                                                                      |                                                                                              | 2b. HOUR<br><b>9:15 am</b>                                                                                                                 |                                                                                                 |                                                  |  |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>caucasian</b>                                                                                                                        |                                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>10 12 1917</b>                                                                                                        |                                                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.                                    |                                                                                              | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                                  |                                                                                                 |                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kiev, USSR</b>                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Stateless</b>                                                                                                   |                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                 |                                                                                              |                                                                                                                                            |                                                                                                 |                                                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>at home - 25 Featherwood Court</b> |                                                                           |                                                                                                                                                             |                                                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |                                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Cold Metal Engineer</b>                                                                            |                                                                                                 |                                                  |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                    |                                                                           |                                                                                                                                                             | 13b. COUNTY<br><b>Montgomery</b>                                      |                                                                                      | 13c. CITY OR TOWN<br><b>Silver Spring</b>                                                    |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Emmanuel RABINOVICH</b>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                    |                                                                           |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rachel Tevish</b> |                                                                                      |                                                                                              |                                                                                                                                            |                                                                                                 |                                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>                                                                                                                                                                                                                                                                               |  |                                                                                                                                                    |                                                                           |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br><b>059-60-9250</b>                        |                                                                                      | 17. INFORMANT<br>ADDRESS<br><b>EFIM A. ITIN, M.D. - 6490 Landover Rd. Landover, MD 20785</b> |                                                                                                                                            |                                                                                                 |                                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Dehydration</b><br>1519<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>widespread metastases</b><br>(c) <b>Gastric Cancer</b>                               |  |                                                                                                                                                    |                                                                           |                                                                                                                                                             |                                                                       |                                                                                      |                                                                                              |                                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>one year</b>                                 |                                                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                                                              |  |                                                                                                                                                    |                                                                           |                                                                                                                                                             |                                                                       |                                                                                      |                                                                                              |                                                                                                                                            |                                                                                                 |                                                  |  |
| 19a. DATE OF OPERATION<br><b>May, 29, 1983.</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Gastric Cancer</b> |                                                                                                                                                             |                                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |                                                                                                 |                                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                     |  |                                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                |                                                                                                                                                             |                                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |                                                                                              |                                                                                                                                            |                                                                                                 |                                                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                    |  |                                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |                                                                                                                                                             |                                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                              |                                                                                                                                            |                                                                                                 |                                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>October, 17, 1983</b> , to <b>October, 27, 1983</b> , that (I) (we) lost saw the deceased alive on <b>October, 18, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                    |                                                                           |                                                                                                                                                             |                                                                       |                                                                                      |                                                                                              |                                                                                                                                            |                                                                                                 |                                                  |  |
| 22b. SIGNATURE<br><b>EFIM A. ITIN</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                    |                                                                           |                                                                                                                                                             |                                                                       | DEGREE<br><b>M.D.</b>                                                                |                                                                                              | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br><b>Oct, 27, 83,</b>          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EFIM A. ITIN</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                    |                                                                           |                                                                                                                                                             |                                                                       | 22e. ADDRESS<br><b>6490 Landover Rd., Landover, M.D. 20785</b>                       |                                                                                              |                                                                                                                                            |                                                                                                 |                                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                    | 23b. DATE<br><b>10-30-83</b>                                              |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Lebanon Cemetery</b>     |                                                                                      |                                                                                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hyattsville, Md.</b>                                                                      |                                                                                                 |                                                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Danzansky-Goldberg Chapels;</b>                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                    |                                                                           |                                                                                                                                                             |                                                                       | ADDRESS<br><b>1170 Rockville Pike</b>                                                |                                                                                              | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 02 1983</b>                                                                                        |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |



*[Faint, illegible text, likely bleed-through from the reverse side of the page.]*



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

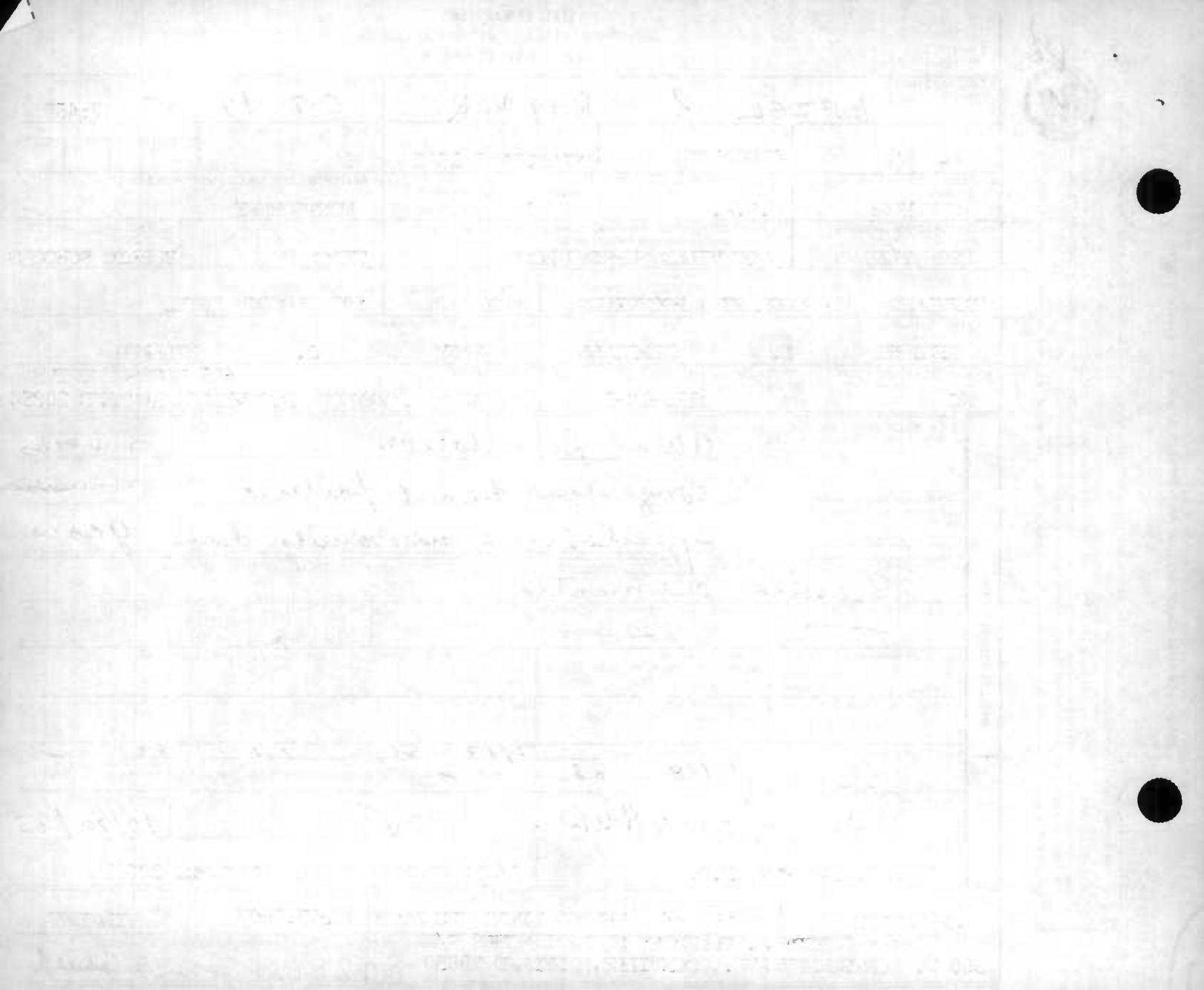
FOR  
1 - STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                     |                                                    |                                                                                                                                                             |                                                                             |                                                                                                                            |                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HAZEL P. RAYNOR.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                     | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Oct. 19 '83 |                                                                                                                                                             |                                                                             | 2b. HOUR<br>7:45P M                                                                                                        |                                                     |  |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br>CAUCASIAN                                                                                                                |                                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>NOVEMBER 1 1892                                                                                                       |                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS.                                                                                 |                                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW YORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                              |                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                                                                     |                                                     |  |
| 10. CITY OR TOWN OF DEATH<br>ROCKVILLE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ROCKVILLE NURSING HOME |                                                    |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>TEACHER |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br>PUBLIC SCHOOLS |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                     |                                                    |                                                                                                                                                             |                                                                             |                                                                                                                            |                                                     |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 13b. COUNTY<br>MONTGOMERY                                                                                                           |                                                    | 13c. CITY OR TOWN<br>ROCKVILLE                                                                                                                              |                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GILBERT L. PEARSALL                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                     |                                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY J. WILLARD                                                                                            |                                                                             |                                                                                                                            |                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>113-18-5633                                                              |                                                    | 17. INFORMANT<br>ADDRESS 605 BLOSSOM DRIVE<br>MARGARET B. RAYNOR ROCKVILLE, MARYLAND 20850                                                                  |                                                                             |                                                                                                                            |                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Actual fibrillation</u><br>4029<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Congestive heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Hypertensive Cardiovascular disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 weeks</u><br><u>2 weeks</u><br><u>years.</u> |  |                                                                                                                                     |                                                    |                                                                                                                                                             |                                                                             |                                                                                                                            |                                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Senile dementia</u>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                     |                                                    |                                                                                                                                                             |                                                                             |                                                                                                                            |                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                    |                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                                                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                          |                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                             |                                                                                                                            |                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                              |                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                             |                                                                                                                            |                                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/13</u> 19 <u>81</u> , to <u>10/19</u> 19 <u>83</u> , that (I) <del>lost</del> lost<br>saw the deceased alive on <u>10/18</u> 19 <u>83</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <del>will</del> <u>did</u> (did not) view the body after death.                                                                                                                               |  |                                                                                                                                     |                                                    |                                                                                                                                                             |                                                                             |                                                                                                                            |                                                     |  |
| 22b. SIGNATURE<br><u>John G. Fawcett</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                     |                                                    | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                                                             | 22c. DATE SIGNED<br>10/20/83                                                                                               |                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOHN G. FAWCETT, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                     |                                                    | 22e. ADDRESS<br>16610 SUGARLAND RD., BOYDS, MD. 20841                                                                                                       |                                                                             |                                                                                                                            |                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br>OCTOBER 20 1983                                                                                                        |                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br>METROPOLITAN CREMATORY                                                                                                |                                                                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ALEXANDRIA VIRGINIA                                                          |                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>ROBERT A. PUMPHREY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                     |                                                    | 24b. DATE REC'D. BY REGISTRAR<br>OCT 25 1983                                                                                                                |                                                                             | 25. REGISTRAR'S SIGNATURE<br><u>John G. Fawcett</u>                                                                        |                                                     |  |
| 300 W. MONTGOMERY AVE., ROCKVILLE, MARYLAND 20850                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                     |                                                    |                                                                                                                                                             |                                                                             |                                                                                                                            |                                                     |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                   |  | REG. NO.                                                                                                                                                    |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Charles W. Rechenbach</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>October 12, 1983</b>                                                                                                 |  |                                                                                                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>Caucasian</b>                                                                                                                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 11, 1911</b>                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.                                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Indiana</b>                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                        |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Pk.</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>linguist</b>                                                                         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>                                                                      |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                   |  | 13b. COUNTY<br><b>Montgomery</b>                                                                                                                            |  | 13c. CITY OR TOWN<br><b>Silver Spg</b>                                                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MICHAEL RECHENBACH</b>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DAISY COTTINGHAM</b>                                                                                    |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>None</b>                                                                            |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Sarah R. Schiebel, Dtr. Carthensburg, Md.</b>                                                                           |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4960</b><br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic obstructive pulmonary disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>15 years</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Coronary artery heart disease</b>                                                                                                                                                                                                                                         |  |                                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                            |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-80</b> , 19 <b>80</b> , to <b>10-12</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>10-11</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                                                      |  |                                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Seruch T. Kimbrell</b> M.D.                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                   |  | 22c. DATE SIGNED<br><b>10-12-83</b>                                                                                                                         |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Seruch T. Kimbrell</b> MD                                                      |  |
| 22e. ADDRESS<br><b>9801 Georgia Ave, Silver Spring, Md.</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                   |  | 22f. DATE REC'D. BY REGISTRAR<br><b>OCT 19 1983</b>                                                                                                         |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br><b>Oct 13, 1983</b>                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>                                                                                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Southland Pk., Md.</b>                                                    |  |
| 24. FUNERAL DIRECTOR<br><b>W. W. Chambers Co, Inc 8655 Georgia Ave Silver Spring Md 20910</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                            |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                               |                                                                                                                                                          |                                                                          |                                                                                                 |                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                               | 2a. DATE OF DEATH                                                                                                                                        |                                                                          | 2b. HOUR                                                                                        |                                   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Catherine L. Redd                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                               | MONTH DAY YEAR<br>10-26-83                                                                                                                               |                                                                          | 1:45 P.M.                                                                                       |                                   |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4. RACE<br>black                                                                                                              | 5. DATE OF BIRTH MONTH DAY YEAR<br>9-14-14                                                                                                               |                                                                          | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br>69 YRS.                               |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Mont. MD.                                               |                                   |
| 10. CITY OR TOWN OF DEATH<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN<br>District of Columbia Washington                                                                                                                                                                                                                                                                           |                                                                                                                               | 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |                                                                          | 13f. STREET ADDRESS<br>150 Seaton Place, N.W. Apt 4                                             |                                   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Lander Lee                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                               | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE<br>Mamie Smith                                                                                                     |                                                                          |                                                                                                 |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no                                                                                                                                                                                                                                                                                                                                                |                                                                                                                               | 16b. SOCIAL SECURITY NO.<br>579 18 6040                                                                                                                  |                                                                          | 17. INFORMANT ADDRESS<br>Mrs. Sylvia Alexander-daughter-2010 East Marshall Place, Landover, Md. |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) Hypertension, severe<br>(c) Arteriosclerotic Cardiovascular Disease<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 min.<br>10 yrs.<br>10 yrs. |                                                                                                                               |                                                                                                                                                          |                                                                          |                                                                                                 |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br>Diabetes, Mellitus, severe (2)                                                                                                                                                                                                                                                                                 |                                                                                                                               |                                                                                                                                                          |                                                                          |                                                                                                 |                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                                          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |                                   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                            |                                                                                                                               |                                                                                                                                                          |                                                                          |                                                                                                 |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                 |                                                                                                                               | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |                                   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                             |                                                                                                                               | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                          | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                  |                                   |
| 22a. I certify that (I) (the hospital) attended the deceased from 10-9-83, 19, to 10-26-83, 19, that (we) last saw the deceased alive on 10-26-83, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                    |                                                                                                                               |                                                                                                                                                          |                                                                          |                                                                                                 |                                   |
| 22b. SIGNATURE<br>George B. Patrick, Jr. MD                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                               | 22c. DATE SIGNED<br>10-26-83                                                                                                                             |                                                                          | 22d. ADDRESS<br>9221 Colesville Rd. Silver Spring, MD 20910                                     |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                               | 23b. DATE<br>Oct. 29, 1983                                                                                                                               |                                                                          | 23c. NAME OF CEMETERY OR CREMATORY<br>Stewart Funeral Home - 4001 Benning Rd., N.               |                                   |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Landover, Md.                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                               | 23e. DATE REC'D. BY REGISTRAR<br>NOV 7 1983                                                                                                              |                                                                          |                                                                                                 |                                   |
| 24. FUNERAL DIRECTOR<br>Stewart Funeral Home                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                               | 25. REGISTRAR'S SIGNATURE<br>John J. Givens                                                                                                              |                                                                          |                                                                                                 |                                   |

MEDICAL CERTIFICATION

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12/11



CHARLES HARRIS

1911-12-11

1911-12-11

1911-12-11

1911-12-11

1911-12-11

1911-12-11

1911-12-11

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                     |  | REG. NO.                                                                                                                                                    |  |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                     |  | 2. DATE OF DEATH MONTH DAY YEAR                                                                                                                             |  |                                                                                                                            |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>Walter F. Reinhart                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                     |  | October 7 1983 M                                                                                                                                            |  |                                                                                                                            |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>White                                                                                                                    |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Nov. 3 1892                                                                                                              |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS.                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br>Gaithersburg                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Wilson Health Care Center |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Station Agent                                                                              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Railroad                                                                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br>Montgomery                                                                                                           |  | 13c. CITY OR TOWN<br>Gaithersburg                                                                                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William - Reinhart                                                                                                                                                                                                                                                                                                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Agnes - Perrell                                                                       |  | 13e. STREET ADDRESS<br>301 Russell Ave., 20877                                                                                                              |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br>705-07-8496                                                                                             |  | 17. INFORMANT ADDRESS<br>Lee R. Prestwood Rt.#1 Box22 The Plains, Va. 22171                                                                                 |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>A.S.H.D. - a systolic</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Atherosclerosis, Genl.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Years</u><br><u>Years</u> |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>C.O.P.D.</u>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                    |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                 |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>55</u> to <u>10-7</u> 19 <u>83</u> , that (I) <del>had</del> lost saw the deceased alive on <u>10-7</u> 19 <u>83</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did</del> (did not) view the body after death.                                                                                                  |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>Jack Schumacher M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                     |  | DEGREE<br>M.D.                                                                                                                                              |  | 22c. DATE SIGNED                                                                                                           |  |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jack Schumacher, M.D.                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                     |  | 23b. ADDRESS<br>105 Russell Ave., Gaithersburg, Md. 20877                                                                                                   |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br>10/11/83                                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Forest Oak Cemetery                                                                                                   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Gaithersburg Montg. Md.                                                         |  |
| 24. FUNERAL DIRECTOR NAME<br>Gartner Sandison F.H.                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                     |  | 316 D. Diamond Ave.<br>Gaithersburg, Md. 20877                                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 13 1983                                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                     |  | 25b. REGISTRAR'S SIGNATURE<br>J. A. G. G. G.                                                                                                                |  |                                                                                                                            |  |

BP



3

RECEIVED  
JAN 10 1941  
U.S. DEPT. OF AGRICULTURE

10

TO: Mr. J. H. ...  
FROM: Mr. ...  
SUBJECT: ...

Dear Sir:  
I have the honor to acknowledge the receipt of your letter of January 8, 1941, regarding the matter of ...

I am sorry that I cannot give you a more definite answer at this time, but the matter is being handled as quickly as possible. I will advise you again as soon as a final decision has been reached.

Very truly yours,  
[Signature]  
[Title]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                   |  |                                                                                                                                         |                                                                  |                                                                                                                                                             |  |                                                                                                 |  |
|-----------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Della M Rhine</b>                          |  |                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>3</b> YEAR <b>83</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>9:12 AM</b>                                                                      |  |
| 3. SEX<br><b>Female</b>                                                           |  | 4. RACE<br><b>White</b>                                                                                                                 |                                                                  | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>12</b> YEAR <b>02</b>                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b>                                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                              |                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |                                                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>H. Wife</b>                                                                          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                                |  |
| 13a. STATE<br><b>Md.</b>                                                          |  | 13b. COUNTY<br><b>Mont.</b>                                                                                                             |                                                                  | 13c. CITY OR TOWN<br><b>Kensington</b>                                                                                                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <b>Frederick</b> MIDDLE <b>A.</b> LAST <b>Reed</b>     |  | 15. MOTHER'S MAIDEN NAME<br>MIDDLE <b>Hefner</b> LAST <b></b>                                                                           |                                                                  | 13e. STREET ADDRESS<br><b>3804 Lawrence Ave.</b>                                                                                                            |  |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b> |  | 16b. SOCIAL SECURITY NO.<br><b>577-14-8055D</b>                                                                                         |                                                                  | 17. INFORMANT<br>ADDRESS<br><b>Charles W. Rhine, Jr. Same as # 13</b>                                                                                       |  |                                                                                                 |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**1991**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**6 months**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                        |  |                                                                        |  |                                                                                      |  |                                                                                                                               |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)       |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |                                                                                                                               |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>Sept 27, 1983</b> to <b>Oct 3, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I have) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                      |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>Francis H. Barber</b>                                                                                                                                                                                                                             |  |                                                                        |  | DEGREE                                                                               |  | 22c. DATE SIGNED<br><b>10-3-83</b>                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Francis H. Barber</b>                                                                                                                                                                                                      |  |                                                                        |  | 22e. ADDRESS<br><b>3720 Foxcroft Ave. Rockville, Md. 20851</b>                       |  |                                                                                                                               |  |

|                                                            |  |                                  |  |                                                        |  |                                                                                     |  |
|------------------------------------------------------------|--|----------------------------------|--|--------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b> |  | 23b. DATE<br><b>Oct. 5, 1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Par Klawn</b> |  | 23d. LOCATION<br>CITY OR TOWN <b>Rockville</b> COUNTY <b>Mont.</b> STATE <b>Md.</b> |  |
|------------------------------------------------------------|--|----------------------------------|--|--------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|

|                                                  |  |                                                    |  |                                                     |  |
|--------------------------------------------------|--|----------------------------------------------------|--|-----------------------------------------------------|--|
| 24. FUNERAL DIRECTOR<br><b>Francis H. Barber</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 7 1983</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b> |  |
|--------------------------------------------------|--|----------------------------------------------------|--|-----------------------------------------------------|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON

CHALKMAN



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |         |                   |                                                             |  |                                              |  |                                                                                                                                                          |                |                     |  |                                                                     |  |             |  |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------|-------------------|-------------------------------------------------------------|--|----------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|---------------------|--|---------------------------------------------------------------------|--|-------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                      |  |         | FIRST MIDDLE LAST |                                                             |  | 2a. DATE KNOWN OF DEATH                      |  |                                                                                                                                                          | MONTH DAY YEAR |                     |  | 2b. HOUR                                                            |  |             |  |  |  |
| Marion Virginia Richardson                                                                                                                                                                                                                                                                                                                                                                                                               |  |         |                   |                                                             |  | 10/23 19 83                                  |  |                                                                                                                                                          |                |                     |  | M                                                                   |  |             |  |  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE |                   | 5. DATE OF BIRTH                                            |  | 6. AGE (IN YEARS)                            |  | IF UNDER 1 YR.                                                                                                                                           |                | IF UNDER 24 HRS.    |  | 7c. DATE PRONOUNCED DEAD                                            |  | 12:30 P. M. |  |  |  |
| Female                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | Black   |                   | Jan. 20, 1916                                               |  | 67 YRS.                                      |  |                                                                                                                                                          |                |                     |  | 10/23 19 83                                                         |  | P. M.       |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                |  |         |                   | 7b. CITIZEN OF WHAT COUNTRY?                                |  |                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                |                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |             |  |  |  |
| Virginia                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |         |                   | U.S.A.                                                      |  |                                              |  |                                                                                                                                                          |                |                     |  | Montgomery County MD                                                |  |             |  |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                |  |         |                   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  |                                              |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |                |                     |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |             |  |  |  |
| Silver Spring                                                                                                                                                                                                                                                                                                                                                                                                                            |  |         |                   | 12237 Bluhill Road                                          |  |                                              |  | Housewife                                                                                                                                                |                |                     |  |                                                                     |  |             |  |  |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                               |  |         |                   | 13b. COUNTY                                                 |  | 13c. CITY OR TOWN                            |  | 13d. INSIDE CITY LIMITS?                                                                                                                                 |                | 13e. STREET ADDRESS |  |                                                                     |  | 20902       |  |  |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |         |                   | Montgomery                                                  |  | Silver Spring                                |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                 |                | 12237 Bluhill Road  |  |                                                                     |  |             |  |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                        |  |         |                   |                                                             |  | 15. MOTHER'S MAIDEN NAME                     |  |                                                                                                                                                          |                |                     |  |                                                                     |  |             |  |  |  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                        |  |         |                   |                                                             |  | FIRST MIDDLE LAST                            |  |                                                                                                                                                          |                |                     |  |                                                                     |  |             |  |  |  |
| Beatrix Lawson                                                                                                                                                                                                                                                                                                                                                                                                                           |  |         |                   |                                                             |  | Sidney Flemming                              |  |                                                                                                                                                          |                |                     |  |                                                                     |  |             |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                                                                                                                                                                                                                                                                                                                                                                             |  |         |                   |                                                             |  | 16b. SOCIAL SECURITY NO.                     |  |                                                                                                                                                          |                |                     |  | 17. INFORMANT ADDRESS                                               |  |             |  |  |  |
| (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                                                                                                                                                                                                        |  |         |                   |                                                             |  | 173-22-7041                                  |  |                                                                                                                                                          |                |                     |  | Geraldine Clay (Daughter) same as #13                               |  |             |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                                |  |         |                   |                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                                          |                |                     |  |                                                                     |  |             |  |  |  |
| PART 1 DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                                                              |  |         |                   |                                                             |  |                                              |  |                                                                                                                                                          |                |                     |  |                                                                     |  |             |  |  |  |
| IMMEDIATE CAUSE (a) 4291 Acute myocardial disease.                                                                                                                                                                                                                                                                                                                                                                                       |  |         |                   |                                                             |  |                                              |  |                                                                                                                                                          |                |                     |  |                                                                     |  |             |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                           |  |         |                   |                                                             |  |                                              |  |                                                                                                                                                          |                |                     |  |                                                                     |  |             |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last                                                                                                                                                                                                                                                                                                                                             |  |         |                   |                                                             |  |                                              |  |                                                                                                                                                          |                |                     |  |                                                                     |  |             |  |  |  |
| (b) _____                                                                                                                                                                                                                                                                                                                                                                                                                                |  |         |                   |                                                             |  |                                              |  |                                                                                                                                                          |                |                     |  |                                                                     |  |             |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                           |  |         |                   |                                                             |  |                                              |  |                                                                                                                                                          |                |                     |  |                                                                     |  |             |  |  |  |
| (c) _____                                                                                                                                                                                                                                                                                                                                                                                                                                |  |         |                   |                                                             |  |                                              |  |                                                                                                                                                          |                |                     |  |                                                                     |  |             |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 101.                                                                                                                                                                                                                                                                                                      |  |         |                   |                                                             |  |                                              |  |                                                                                                                                                          |                |                     |  |                                                                     |  |             |  |  |  |
| None                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |         |                   |                                                             |  |                                              |  |                                                                                                                                                          |                |                     |  |                                                                     |  |             |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |  |         |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |                                              |  |                                                                                                                                                          |                |                     |  | 20. AUTOPSY?                                                        |  |             |  |  |  |
| None                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |         |                   |                                                             |  |                                              |  |                                                                                                                                                          |                |                     |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |             |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                      |  |         |                   | 21b. TIME OF INJURY                                         |  |                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |                |                     |  |                                                                     |  |             |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |         |                   | HOUR A.M. MONTH DAY YEAR                                    |  |                                              |  | None                                                                                                                                                     |                |                     |  |                                                                     |  |             |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |         |                   | P.M. 19                                                     |  |                                              |  |                                                                                                                                                          |                |                     |  |                                                                     |  |             |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                          |  |         |                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |                                              |  | 21f. LOCATION                                                                                                                                            |                |                     |  |                                                                     |  |             |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |         |                   |                                                             |  |                                              |  | STREET CITY OR TOWN COUNTY STATE                                                                                                                         |                |                     |  |                                                                     |  |             |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |         |                   |                                                             |  |                                              |  |                                                                                                                                                          |                |                     |  |                                                                     |  |             |  |  |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                         |  |         |                   | TITLE (SPECIFY)                                             |  |                                              |  | MEDICAL EXAMINER                                                                                                                                         |                |                     |  | DATE SIGNED                                                         |  |             |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                          |  |         |                   | ADDRESS                                                     |  |                                              |  |                                                                                                                                                          |                |                     |  | 10/24/83                                                            |  |             |  |  |  |
| John S. Rogers, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                     |  |         |                   | Silver Spring, Montgomery, Md.                              |  |                                              |  |                                                                                                                                                          |                |                     |  |                                                                     |  |             |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                |  |         |                   | 23b. DATE                                                   |  |                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                |                     |  | 23d. LOCATION                                                       |  |             |  |  |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |         |                   | 10-26-83                                                    |  |                                              |  | Gate of Heaven                                                                                                                                           |                |                     |  | Silver Spring, Montg. Md.                                           |  |             |  |  |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                                                                                |  |         |                   | 25a. DATE REC'D. BY REGISTRAR                               |  |                                              |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                               |                |                     |  |                                                                     |  |             |  |  |  |
| George R. Snowden                                                                                                                                                                                                                                                                                                                                                                                                                        |  |         |                   | 246 N. Washington St. Rockville, Md. 20850                  |  |                                              |  | OCT 27 1983                                                                                                                                              |                |                     |  | John J. Conner                                                      |  |             |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (15))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  | REG. NO. 27828                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|---------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  |                                                               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MICHAEL DAVID RICKERDS</b>                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <b>10-22-83</b>                       |  |
| 2. SEX <b>Male</b> 3. RACE <b>White</b> 4. DATE OF BIRTH <b>June 20, 1966</b> 5. AGE (IN YEARS LAST BIRTHDAY) <b>17</b> YRS.                                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | 2b. DATE OF DEATH <b>10-22-83</b>                             |  |
| 6. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  | 2c. DATE PRONOUNCED DEAD <b>10-22-83</b>                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b> 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> |  |
| 10. CITY OR TOWN OF DEATH <b>Mt. Airy</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rt. 27, 300' S. of Brown Church Rd.</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>High School</b>                                                                                                         |  |  |  |  |  |  |  |  |  |                                                               |  |
| 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Frederick</b> 13c. CITY OR TOWN <b>Mt. Airy</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>4303 Millwood Rd. 21771</b>                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  |                                                               |  |
| 14. FATHER'S NAME <b>John Thomas Rickerds</b> 15. MOTHER'S MAIDEN NAME <b>Pamela Frances Book</b>                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  |                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. <b>215-98-4522</b> 17. INFORMANT <b>John T. Rickerds,</b> ADDRESS <b>Item 13</b>                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  |                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>8120</b> IMMEDIATE CAUSE (a) <b>Cranio-cerebral injury</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                               |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  |                                                               |  |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  |                                                               |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>1:00AM 10-22-83</b> 21b. TIME OF INJURY <b>1:00AM 10-22-83</b> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>driver of auto/auto head-on collision</b>                                                                                                            |  |  |  |  |  |  |  |  |  |                                                               |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>hwy.</b> 21f. LOCATION <b>Rt. 27, 300' S. of Brown Church Road</b> CITY OR TOWN <b>Montgomery Co., Maryland</b>                                                                                                                                       |  |  |  |  |  |  |  |  |  |                                                               |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |                                                               |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b> TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER DATE SIGNED <b>10-22-83</b>                                                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  |                                                               |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b> ADDRESS <b>111 Penn Street</b>                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  |                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>Oct. 24, 1983</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Poplar Springs</b> 23d. LOCATION CITY OR TOWN <b>Poplar Springs, Howard, Md.</b> COUNTY <b>Howard</b> STATE <b>Md.</b>                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  |                                                               |  |
| 24. FUNERAL DIRECTOR NAME <b>Olin L. Molesworth, P.A., Damascus, Md.</b> ADDRESS 25a. DATE REC'D. BY REGISTRAR <b>OCT 26 1983</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  |                                                               |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                 |  |                                                                                                                                                             |                                                      |                                                                                                                                            |  |                                                                                                                                       |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                 |  |                                                                                                                                                             | REG. NO.                                             |                                                                                                                                            |  |                                                                                                                                       |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>KENNETH MOTT ROBINSON                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                 |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>OCTOBER 12, 1983 |                                                                                                                                            |  | 2b. HOUR<br>1:25 a.m.                                                                                                                 |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br>WHITE                                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>AUGUST 12, 1928                                                                                                          |                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS                                                                                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Kansas                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                             |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY COUNTY, MD.                                                                             |  |                                                                                                                                       |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CLINICAL CENTER (NIH) |  |                                                                                                                                                             |                                                      | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Physician                                                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Self                                                                                             |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY<br>Montgomery                                                                                                       |  | 13c. CITY OR TOWN<br>BETHESDA                                                                                                                               |                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                       |  | 13e. STREET ADDRESS<br>5421 WEHAWKEN RD 20816                                                                                         |  |
| 14. FATHER'S NAME<br>Mott L. Robinson                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME<br>Katie M. Fearey                                                                                                                 |                                                      |                                                                                                                                            |  |                                                                                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                                                                                                                |  | (IF YES, GIVE WAR OR DATES)<br>Korean                                                                                           |  | 16b. SOCIAL SECURITY NO.<br>495-24-8053                                                                                                                     |                                                      | 17. INFORMANT ADDRESS<br>Johnna Robinson (wife) same as patient                                                                            |  |                                                                                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Transtentorial herniation of brain secondary to Glioblastoma multiforme</u><br>7420<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                 |  |                                                                                                                                                             |                                                      |                                                                                                                                            |  |                                                                                                                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                 |  |                                                                                                                                                             |                                                      |                                                                                                                                            |  |                                                                                                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                |  |                                                                                                                                                             |                                                      | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)                                                                             |                                                      |                                                                                                                                            |  |                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                          |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                      |                                                                                                                                            |  |                                                                                                                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 21, 1983</u> to <u>OCT. 12, 1983</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>OCT. 12, 1983</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death. |  |                                                                                                                                 |  |                                                                                                                                                             |                                                      |                                                                                                                                            |  |                                                                                                                                       |  |
| 22b. SIGNATURE<br>B. Wittkind, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                 |  | DEGREE<br>M.D.                                                                                                                                              |                                                      | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>10/12/83                                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>B. Wittkind, M.D.                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                 |  | 22e. ADDRESS<br>National Institutes of Health<br>Clinical Center, Bethesda, Md, 20205                                                                       |                                                      |                                                                                                                                            |  |                                                                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br>10/14/1983                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Univ. of Kansas Medical Cen.                                                                                          |                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Kansas City, Kansas                                                                          |  |                                                                                                                                       |  |
| 24. FUNERAL DIRECTOR<br>Joseph Gawler's Sons Inc.<br>5130 Wisc. Ave., N.W. Wash., D.C.                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 19 1983                                                                                                                |                                                      | 25b. REGISTRAR'S SIGNATURE<br>R. E. Conrad                                                                                                 |  |                                                                                                                                       |  |

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| No.  |      | Name |      | Country |      | Date |      |
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| 765  | 766  | 767  | 768  | 769     | 770  | 771  | 772  |
| 773  | 774  | 775  | 776  | 777     | 778  | 779  | 780  |
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| 797  | 798  | 799  | 800  | 801     | 802  | 803  | 804  |
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| 885  | 886  | 887  | 888  | 889     | 890  | 891  | 892  |
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| 909  | 910  | 911  | 912  | 913     | 914  | 915  | 916  |
| 917  | 918  | 919  | 920  | 921     | 922  | 923  | 924  |
| 925  | 926  | 927  | 928  | 929     | 930  | 931  | 932  |
| 933  | 934  | 935  | 936  | 937     | 938  | 939  | 940  |
| 941  | 942  | 943  | 944  | 945     | 946  | 947  | 948  |
| 949  | 950  | 951  | 952  | 953     | 954  | 955  | 956  |
| 957  | 958  | 959  | 960  | 961     | 962  | 963  | 964  |
| 965  | 966  | 967  | 968  | 969     | 970  | 971  | 972  |
| 973  | 974  | 975  | 976  | 977     | 978  | 979  | 980  |
| 981  | 982  | 983  | 984  | 985     | 986  | 987  | 988  |
| 989  | 990  | 991  | 992  | 993     | 994  | 995  | 996  |
| 997  | 998  | 999  | 1000 | 1001    | 1002 | 1003 | 1004 |
| 1005 | 1006 | 1007 | 1008 | 1009    | 1010 | 1011 | 1012 |
| 1013 | 1014 | 1015 | 1016 | 1017    | 1018 | 1019 | 1020 |
| 1021 | 1022 | 1023 | 1024 | 1025    | 1026 | 1027 | 1028 |
| 1029 | 1030 | 1031 | 1032 | 1033    | 1034 | 1035 | 1036 |
| 1037 | 1038 | 1039 | 1040 | 1041    | 1042 | 1043 | 1044 |
| 1045 | 1046 | 1047 | 1048 | 1049    | 1050 | 1051 | 1052 |
| 1053 | 1054 | 1055 | 1056 | 1057    | 1058 | 1059 | 1060 |
| 1061 | 1062 | 1063 | 1064 | 1065    | 1066 | 1067 | 1068 |
| 1069 | 1070 | 1071 | 1072 | 1073    | 1074 | 1075 | 1076 |
| 1077 | 1078 | 1079 | 1080 | 1081    | 1082 | 1083 | 1084 |
| 1085 | 1086 | 1087 | 1088 | 1089    | 1090 | 1091 | 1092 |
| 1093 | 1094 | 1095 | 1096 | 1097    | 1098 | 1099 | 1100 |
| 1101 | 1102 | 1103 | 1104 | 1105    | 1106 | 1107 | 1108 |
| 1109 | 1110 | 1111 | 1112 | 1113    | 1114 | 1115 | 1116 |
| 1117 | 1118 | 1119 | 1120 | 1121    | 1122 | 1123 | 1124 |
| 1125 | 1126 | 1127 | 1128 | 1129    | 1130 | 1131 | 1132 |
| 1133 | 1134 | 1135 | 1136 | 1137    | 1138 | 1139 | 1140 |
| 1141 | 1142 | 1143 | 1144 | 1145    | 1146 | 1147 | 1148 |
| 1149 | 1150 | 1151 | 1152 | 1153    | 1154 | 1155 | 1156 |
| 1157 | 1158 | 1159 | 1160 | 1161    | 1162 | 1163 | 1164 |
| 1165 | 1166 | 1167 | 1168 | 1169    | 1170 | 1171 | 1172 |
| 1173 | 1174 | 1175 | 1176 | 1177    | 1178 | 1179 | 1180 |
| 1181 | 1182 | 1183 | 1184 | 1185    | 1186 | 1187 | 1188 |
| 1189 | 1190 | 1191 | 1192 | 1193    | 1194 | 1195 | 1196 |
| 1197 | 1198 | 1199 | 1200 | 1201    | 1202 | 1203 | 1204 |
| 1205 | 1206 | 1207 | 1208 | 1209    | 1210 | 1211 | 1212 |
| 1213 | 1214 | 1215 | 1216 | 1217    | 1218 | 1219 | 1220 |
| 1221 | 1222 | 1223 | 1224 | 1225    | 1226 | 1227 | 1228 |
| 1229 | 1230 | 1231 | 1232 | 1233    | 1234 | 1235 | 1236 |
| 1237 | 1238 | 1239 | 1240 | 1241    | 1242 | 1243 | 1244 |
| 1245 | 1246 | 1247 | 1248 | 1249    | 1250 | 1251 | 1252 |
| 1253 | 1254 | 1255 | 1256 | 1257    | 1258 | 1259 | 1260 |
| 1261 | 1262 | 1263 | 1264 | 1265    | 1266 | 1267 | 1268 |
| 1269 | 1270 | 1271 | 1272 | 1273    | 1274 | 1275 | 1276 |
| 1277 | 1278 | 1279 | 1280 | 1281    | 1282 | 1283 | 1284 |
| 1285 | 1286 | 1287 | 1288 | 1289    | 1290 | 1291 | 1292 |
| 1293 | 1294 | 1295 | 1296 | 1297    | 1298 | 1299 | 1300 |
| 1301 | 1302 | 1303 | 1304 | 1305    | 1306 | 1307 | 1308 |
| 1309 | 1310 | 1311 | 1312 | 1313    | 1314 | 1315 | 1316 |
| 1317 | 1318 | 1319 | 1320 | 1321    | 1322 | 1323 | 1324 |
| 1325 | 1326 | 1327 | 1328 | 1329    | 1330 | 1331 | 1332 |
| 1333 | 1334 | 1335 | 1336 | 1337    | 1338 | 1339 | 1340 |
| 1341 | 1342 | 1343 | 1344 | 1345    | 1346 | 1347 | 1348 |
| 1349 | 1350 | 1351 | 1352 | 1353    | 1354 | 1355 | 1356 |
| 1357 | 1358 | 1359 | 1360 | 1361    | 1362 | 1363 | 1364 |
| 1365 | 1366 | 1367 | 1368 | 1369    | 1370 | 1371 | 1372 |
| 1373 | 1374 | 1375 | 1376 | 1377    | 1378 | 1379 | 1380 |
| 1381 | 1382 | 1383 | 1384 | 1385    | 1386 | 1387 | 1388 |
| 1389 | 1390 | 1391 | 1392 | 1393    | 1394 | 1395 | 1396 |
| 1397 | 1398 | 1399 | 1400 | 1401    | 1402 | 1403 | 1404 |
| 1405 | 1406 | 1407 | 1408 | 1409    | 1410 | 1411 | 1412 |
| 1413 | 1414 | 1415 | 1416 | 1417    | 1418 | 1419 | 1420 |
| 1421 | 1422 | 1423 | 1424 | 1425    | 1426 | 1427 | 1428 |
| 1429 | 1430 | 1431 | 1432 | 1433    | 1434 | 1435 | 1436 |
| 1437 | 1438 | 1439 | 1440 | 1441    | 1442 | 1443 | 1444 |
| 1445 | 1446 | 1447 | 1448 | 1449    | 1450 | 1451 | 1452 |
| 1453 | 1454 | 1455 | 1456 | 1457    | 1458 | 1459 | 1460 |
| 1461 | 1462 | 1463 | 1464 | 1465    | 1466 | 1467 | 1468 |
| 1469 | 1470 | 1471 | 1472 | 1473    |      |      |      |

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                   |  |                                                                                                                                          |  |                                                                                    |  |                                                                                                 |  |                                                                   |      |                                 |     |                 |          |                  |
|-----------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------|------|---------------------------------|-----|-----------------|----------|------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LILLIAN</b>                                |  | FIRST <b>ROBINSON</b>                                                                                                                    |  | MIDDLE                                                                             |  | LAST                                                                                            |  | 2a. DATE OF DEATH                                                 |      | MONTH                           | DAY | YEAR            | 2b. HOUR |                  |
|                                                                                   |  |                                                                                                                                          |  |                                                                                    |  |                                                                                                 |  | 10                                                                |      | 8                               | 83  | 8:10 P.M.       |          |                  |
| 3. SEX<br><b>F</b>                                                                |  | 4. RACE<br><b>Black</b>                                                                                                                  |  | 5. DATE OF BIRTH                                                                   |  | MONTH                                                                                           |  | DAY                                                               | YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) |     | IF UNDER 1 YEAR |          | IF UNDER 24 HRS. |
|                                                                                   |  |                                                                                                                                          |  | 12                                                                                 |  | 3                                                                                               |  | 1999                                                              |      | 83                              |     | MONTHS          |          | DAYS             |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Washington, D.C.</b>           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>         |  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery Co. MD.</b> |      |                                 |     |                 |          |                  |
| 10. CITY OR TOWN OF DEATH<br><b>Maryland</b>                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bureau of Engraving</b>                                 |  |                                                                   |      |                                 |     |                 |          |                  |
| 13a. STATE<br><b>D. C.</b>                                                        |  | 13b. COUNTY                                                                                                                              |  | 13c. CITY OR TOWN<br><b>Washington</b>                                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>140 T Street, N.E.</b>                  |      |                                 |     |                 |          |                  |
| 14. FATHER'S NAME<br>FIRST <b>John T.</b> MIDDLE <b>Robinson</b> LAST             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Bessie</b> MIDDLE <b>Johnson</b> LAST                                                               |  |                                                                                    |  |                                                                                                 |  |                                                                   |      |                                 |     |                 |          |                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>579-01-9729</b>                                                            |  | 17. INFORMANT<br><b>140 T Street, N.E.</b>                                         |  | ADDRESS                                                                                         |  |                                                                   |      |                                 |     |                 |          |                  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

4100

IMMEDIATE CAUSE (a) **Cardiac arrest**

DUE TO, OR AS A CONSEQUENCE OF

(b) **myocardial infarction**

DUE TO, OR AS A CONSEQUENCE OF

(c) **coronary artery disease**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**hr of cancer of colon**

|                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                               |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                                                               |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>10/5</b> , 19 <b>83</b> , to <b>10/8</b> , 19 <b>83</b> , that (1) (we) last saw the deceased alive on <b>10/8</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>Kathleen McShane MD</b>                                                                                                                                                                                                                                                                                                                       |  | DEGREE<br><b>MD</b>                                                    |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10/8/83</b>                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KATHLEEN McSHANE</b>                                                                                                                                                                                                                                                                                                   |  | 22e. ADDRESS<br><b>Landover Md</b>                                     |  | 22f. ADDRESS<br><b>Kaiser Landover Med. Center</b>                                                                                         |  |                                                                                                                               |  |

|                                                                                          |  |                              |  |                                                                                                      |  |                                                                    |  |
|------------------------------------------------------------------------------------------|--|------------------------------|--|------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>                               |  | 23b. DATE<br><b>10-13-83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Harmony Memorial Park</b>                                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Landover, Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>John T. Rhines Co., 3015 12th St. N.E., D.C.</b> ADDRESS |  |                              |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>OCT 13 1983</b> <b>John T. Rhines</b> |  |                                                                    |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

200

100

100  
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1000

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                 |  |                                                                     |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                      |  | REG. NO.                                                                                               |  |                                                                                                                                                          |  |                                                                                                                                 |  |                                                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                            |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                   |  | LAST                                                                                                                            |  | 2e. DATE OF DEATH MONTH DAY YEAR 2b. HOUR                           |  |
| HILDA                                                                                                                                                                                                                                                                                                       |  | B                                                                                                      |  | RUBAKER                                                                                                                                                  |  | ROTHGEB                                                                                                                         |  | 10 7 83 10 <sup>36</sup> A                                          |  |
| 3. SEX                                                                                                                                                                                                                                                                                                      |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                 |  | IF UNDER 1 YEAR IF UNDER 24 HRS.                                    |  |
| Female                                                                                                                                                                                                                                                                                                      |  | CAUCASIAN                                                                                              |  | MONTH DAY YEAR 1 4 1902                                                                                                                                  |  | 81 YRS.                                                                                                                         |  | MONTHS DAYS HOURS MIN.                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                            |  |                                                                     |  |
| Wash D.C.                                                                                                                                                                                                                                                                                                   |  | U.S.A.                                                                                                 |  |                                                                                                                                                          |  | Mont MD.                                                                                                                        |  |                                                                     |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IS NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Bethesda                                                                                                                                                                                                                                                                                                    |  | Suburban Hospital                                                                                      |  |                                                                                                                                                          |  | CLERK                                                                                                                           |  | INSURANCE                                                           |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                     |  | 13a. STATE                                                                                             |  | 13b. COUNTY                                                                                                                                              |  | 13c. CITY OR TOWN                                                                                                               |  | 13d. INSIDE CITY LIMITS?                                            |  |
|                                                                                                                                                                                                                                                                                                             |  | D.C.                                                                                                   |  |                                                                                                                                                          |  | WASHINGTON                                                                                                                      |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME                                                                               |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                        |  | 16b. SOCIAL SECURITY NO.                                                                                                        |  | 17. INFORMANT                                                       |  |
| Grant                                                                                                                                                                                                                                                                                                       |  | Reddish                                                                                                |  | NO                                                                                                                                                       |  | N/A                                                                                                                             |  | LARRY SON                                                           |  |
|                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                 |  | ADDRESS 6933 RACEHORSE LANE                                         |  |
|                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                 |  | BRUBAKER ROCKVILLE, MD. 20852                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                 |  |                                                                     |  |
| 4413 IMMEDIATE CAUSE (a) Cardiac Arrest                                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                 |  |                                                                     |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Hemorrhagic Shock                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                 |  |                                                                     |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Rupture and Aortic Aneurysm                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                 |  |                                                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: atherosclerotic heart disease                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                 |  |                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |                                                                                                                                                          |  | 20a. AUTOPSY?                                                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
| 10/7/83                                                                                                                                                                                                                                                                                                     |  | Ruptured aeurysm                                                                                       |  |                                                                                                                                                          |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                        |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                          |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                                                 |  |                                                                     |  |
|                                                                                                                                                                                                                                                                                                             |  | P.M. 19                                                                                                |  |                                                                                                                                                          |  |                                                                                                                                 |  |                                                                     |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                 |  |                                                                     |  |
|                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                 |  |                                                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/7 1983, to 10/7 1983, that (I) (we) last saw the deceased alive on 10/7 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                 |  |                                                                     |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                              |  | DEGREE                                                                                                 |  |                                                                                                                                                          |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED                                                    |  |
| BARRY J. LEVIN                                                                                                                                                                                                                                                                                              |  | MD                                                                                                     |  |                                                                                                                                                          |  |                                                                                                                                 |  | 10/7/83                                                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                       |  | 22e. ADDRESS                                                                                           |  |                                                                                                                                                          |  |                                                                                                                                 |  |                                                                     |  |
| BARRY J. LEVIN                                                                                                                                                                                                                                                                                              |  | 4801 MASS AVE, N.W.                                                                                    |  |                                                                                                                                                          |  |                                                                                                                                 |  |                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                   |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                         |  |                                                                     |  |
| CREMATION                                                                                                                                                                                                                                                                                                   |  | OCT. 8, 1983                                                                                           |  | METROPOLITAN CREMATORY                                                                                                                                   |  | ALEXANDRIA VIRGINIA                                                                                                             |  |                                                                     |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                   |  | 25a. DATE REC'D. BY REGISTRAR                                                                          |  |                                                                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE                                                                                                      |  |                                                                     |  |
| FRANCIS J. COLLINS                                                                                                                                                                                                                                                                                          |  | OCT 13 1983                                                                                            |  |                                                                                                                                                          |  | John J. Carver                                                                                                                  |  |                                                                     |  |
| 500 UNIVERSITY BLVD., W. SILVER SPRING, MD.                                                                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                 |  |                                                                     |  |

CREMATION OCT. 8, 1983 METROPOLITAN CREMATION  
FRANCIS J. COLLINS



# STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                  |        |                                                                                                                                                             |         |                                                                                                                            |                                              |        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--------|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                   |  | 2a. DATE OF DEATH                                                                                                                |        | MONTH                                                                                                                                                       | DAY     | YEAR                                                                                                                       | 2b. HOUR                                     |        |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                            |  | FIRST                                                                                                                            | MIDDLE | LAST                                                                                                                                                        | 10-8-83 |                                                                                                                            |                                              | 3:27 M |
| 2. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br>White                                                                                                                 |        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>October 13, 1927                                                                                                      |         | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS.                                                                                 |                                              |        |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                                                                                         |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery Co. MD.                                                                 |                                              |        |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Office Manager                                                                          |         | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S.P.D.I.                                                                            |                                              |        |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY<br>Montgomery                                                                                                        |        | 13c. CITY OR TOWN<br>Silver Spring                                                                                                                          |         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                              |        |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Zelik Forman                                                                                                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br>Masha (Unknown) <sup>1ST</sup>                                                       |        | 13e. STREET ADDRESS<br>12611 Davan Drive 20904                                                                                                              |         |                                                                                                                            |                                              |        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>055-20-1142                                                           |        | 17. INFORMANT<br>ADDRESS<br>Seymour N. Rothenberg (Same as # 13)                                                                                            |         |                                                                                                                            |                                              |        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u><br>1749<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>BREAST CARCINOMA, RIGHT (1976)</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                  |        |                                                                                                                                                             |         |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____                                                                                                                                                                                                                                                      |  |                                                                                                                                  |        |                                                                                                                                                             |         |                                                                                                                            |                                              |        |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |        | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |        |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                       |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |         |                                                                                                                            |                                              |        |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                           |        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |         |                                                                                                                            |                                              |        |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>76</u> , to <u>10/8</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>10/8</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.                                      |  |                                                                                                                                  |        |                                                                                                                                                             |         |                                                                                                                            |                                              |        |
| 22b. SIGNATURE<br><u>G. Lennard Gold, M.D.</u>                                                                                                                                                                                                                                                                                                                                                 |  | DEGREE                                                                                                                           |        | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |         | 22c. DATE SIGNED<br><u>10/8/83</u>                                                                                         |                                              |        |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>G. Lennard Gold, M. D.                                                                                                                                                                                                                                                                                                                                |  | 22e. ADDRESS<br>8630 Fenton Street, Silver Spring, Md.                                                                           |        |                                                                                                                                                             |         |                                                                                                                            |                                              |        |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>BURIAL</u>                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br><u>10/10/1983</u>                                                                                                   |        | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Judean Memorial Gardens</u>                                                                                        |         | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Olney, Montgomery, Md.</u>                                                |                                              |        |
| 24. FUNERAL DIRECTOR<br><u>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</u>                                                                                                                                                                                                                                                                                                                    |  | 25a. DATE REC'D. BY REGISTRAR<br><u>OCT 13 1983</u>                                                                              |        | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Connel</u>                                                                                                         |         |                                                                                                                            |                                              |        |
| 23e. CARROLL STREET, N. W., WASHINGTON, D. C.                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                  |        |                                                                                                                                                             |         |                                                                                                                            |                                              |        |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

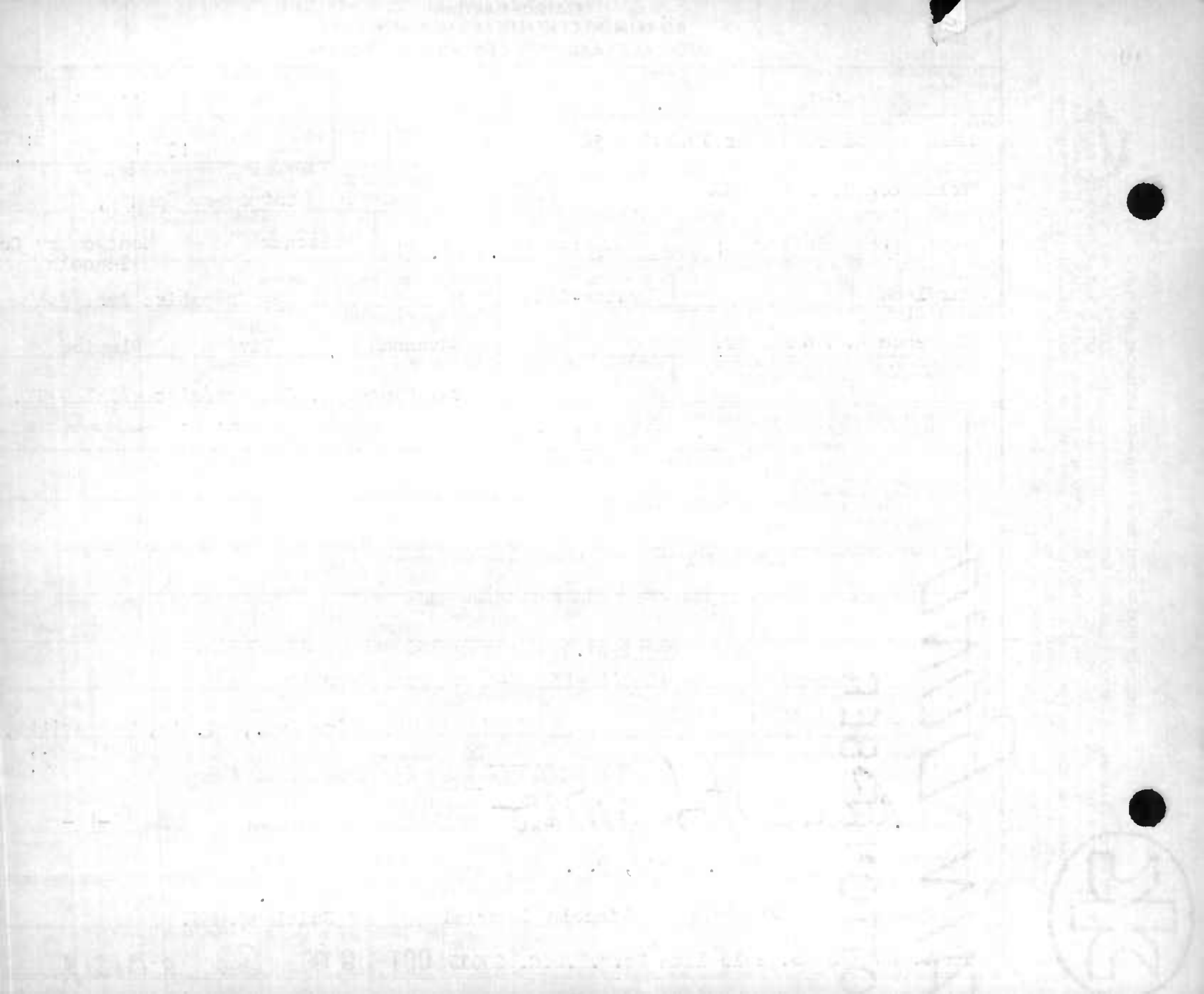




TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, USE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                  |  |                                                                                                                                                 |  |                                                                            |  |                                                                                                                                                             |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |                                                               |  |                                                                                     |  |                                              |  |                                                     |  | 27833                     |  | REG. NO. |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------|--|---------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|----------------------------------------------|--|-----------------------------------------------------|--|---------------------------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST: Calvin, MIDDLE: C., LAST: Rubens                                                                                                                                                                                                                                                                                                                                                                      |  |                  |  |                                                                                                                                                 |  |                                                                            |  |                                                                                                                                                             |  | 2a. DATE KNOWN OF DEATH<br>MONTH: 10, DAY: 11, YEAR: 1983                          |  |                                                               |  |                                                                                     |  |                                              |  |                                                     |  | 2b. HOUR<br>M: 5:00, P.M. |  |          |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br>Black |  | 5. DATE OF BIRTH<br>MONTH: Mar, DAY: 13, YEAR: 1929                                                                                             |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY: 54 YRS.                                |  | IF UNDER 24 HRS.<br>MONTHS: , DAYS: , HOURS: , MIN: .                                                                                                       |  | 7c. DATE PRONOUNCED DEAD<br>MONTH: 10, DAY: 12, YEAR: 1983                         |  | 7d. HOUR<br>P.M.                                              |  |                                                                                     |  |                                              |  |                                                     |  |                           |  |          |  |
| 7a. BIRTHPLACE (STATE OR COUNTY)<br>Darlington, S.C.                                                                                                                                                                                                                                                                                                                                                                                             |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                             |  |                                                                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD |  |                                                                                     |  |                                              |  |                                                     |  |                           |  |          |  |
| 10. CITY OR TOWN OF DEATH<br>Hyattsville                                                                                                                                                                                                                                                                                                                                                                                                         |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>7401 New Hampshire Ave., Apt. 519 |  |                                                                            |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Teacher                                                                                    |  |                                                                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Scuools                  |  |                                                                                     |  |                                              |  |                                                     |  |                           |  |          |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                  |  | 13c. CITY OR TOWN<br>Hyattsville                                                                                                                |  |                                                                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  |                                                                                    |  | 13e. STREET ADDRESS<br>7401 New Hampshire Ave. #519           |  |                                                                                     |  |                                              |  |                                                     |  |                           |  |          |  |
| 14. FATHER'S NAME<br>FIRST: Clarence A., MIDDLE: Ruben, Sr., LAST: .                                                                                                                                                                                                                                                                                                                                                                             |  |                  |  |                                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME<br>FIRST: Savannah, MIDDLE: Vivian, LAST: Fleming |  |                                                                                                                                                             |  |                                                                                    |  |                                                               |  |                                                                                     |  |                                              |  |                                                     |  |                           |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                            |  |                  |  | 16b. SOCIAL SECURITY NO.                                                                                                                        |  |                                                                            |  | 17. INFORMANT<br>ADDRESS: Mrs. Phoebe R. Johnson/sister/212 0 ST.                                                                                           |  |                                                                                    |  |                                                               |  |                                                                                     |  |                                              |  |                                                     |  |                           |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Strangulation</u><br><u>9630</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                                                 |  |                  |  |                                                                                                                                                 |  |                                                                            |  |                                                                                                                                                             |  |                                                                                    |  |                                                               |  | S. W.                                                                               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                     |  |                           |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                               |  |                  |  |                                                                                                                                                 |  |                                                                            |  |                                                                                                                                                             |  |                                                                                    |  |                                                               |  |                                                                                     |  |                                              |  |                                                     |  |                           |  |          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                               |  |                                                                            |  |                                                                                                                                                             |  |                                                                                    |  |                                                               |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                              |  |                                                     |  |                           |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                   |  |                  |  | 21b. TIME OF INJURY (est.)<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 10 11 1983                                                                     |  |                                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject was strangled                                                      |  |                                                                                    |  |                                                               |  |                                                                                     |  |                                              |  |                                                     |  |                           |  |          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Home                                                                             |  |                                                                            |  | 21f. LOCATION<br>STREET: 7401 New Hampshire Ave., Apt. 519, CITY OR TOWN: Hyattsville, COUNTY: Montgomery Co., STATE: Md.                                   |  |                                                                                    |  |                                                               |  |                                                                                     |  |                                              |  |                                                     |  |                           |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                  |  |                                                                                                                                                 |  |                                                                            |  |                                                                                                                                                             |  |                                                                                    |  |                                                               |  |                                                                                     |  |                                              |  |                                                     |  |                           |  |          |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>                                                                                                                                                                                                                                                                                                                                                                                                       |  |                  |  | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER                                                                                                   |  |                                                                            |  |                                                                                                                                                             |  |                                                                                    |  |                                                               |  | DATE SIGNED<br>10-13-83                                                             |  |                                              |  |                                                     |  |                           |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Dennis F. Smyth, M.D.                                                                                                                                                                                                                                                                                                                                                                                         |  |                  |  | ADDRESS<br>111 Penn Street                                                                                                                      |  |                                                                            |  |                                                                                                                                                             |  |                                                                                    |  |                                                               |  |                                                                                     |  |                                              |  |                                                     |  |                           |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                              |  |                  |  | 23b. DATE<br>10-18-83                                                                                                                           |  |                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lincoln Memorial                                                                                                      |  |                                                                                    |  | 23d. LOCATION<br>CITY OR TOWN: Suitland, COUNTY: Md., STATE:  |  |                                                                                     |  |                                              |  |                                                     |  |                           |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME: John T. Rhines Co., ADDRESS: 3015 12th St. N.E.D.C. 20017                                                                                                                                                                                                                                                                                                                                                          |  |                  |  |                                                                                                                                                 |  |                                                                            |  |                                                                                                                                                             |  |                                                                                    |  |                                                               |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 19 1983                                        |  |                                              |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i> |  |                           |  |          |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                         |  |  |  | REG. NO.                                                                                                                                                 |  |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                       |  |  |  | 2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST                                                                                                       |  |  |  |
| Dennis H Ruck                                                                                                                                                                                                                                                                                                                |  |  |  | 2b. DATE OF DEATH MONTH DAY YEAR                                                                                                                         |  |  |  |
| 10/7 October 7, 1983                                                                                                                                                                                                                                                                                                         |  |  |  | 2b. HOUR                                                                                                                                                 |  |  |  |
| 4:40 M                                                                                                                                                                                                                                                                                                                       |  |  |  | 3. SEX                                                                                                                                                   |  |  |  |
| Male                                                                                                                                                                                                                                                                                                                         |  |  |  | 4. RACE                                                                                                                                                  |  |  |  |
| White                                                                                                                                                                                                                                                                                                                        |  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  |  |  |
| 5 6 '38                                                                                                                                                                                                                                                                                                                      |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.                                                                                   |  |  |  |
| 55                                                                                                                                                                                                                                                                                                                           |  |  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                |  |  |  |
| England                                                                                                                                                                                                                                                                                                                      |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                                             |  |  |  |
| U.S.A.                                                                                                                                                                                                                                                                                                                       |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                    |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                                     |  |  |  |
| Silver Spring                                                                                                                                                                                                                                                                                                                |  |  |  | Montgomery MD.                                                                                                                                           |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                                                                                                                                                                                                       |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  |  |  |
| Holy Cross Hospital                                                                                                                                                                                                                                                                                                          |  |  |  | Vice-President                                                                                                                                           |  |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                            |  |  |  | 13a. STREET ADDRESS                                                                                                                                      |  |  |  |
| Riggs National Bank                                                                                                                                                                                                                                                                                                          |  |  |  | 4114 Lynn Burke Road 21770                                                                                                                               |  |  |  |
| 13b. STATE                                                                                                                                                                                                                                                                                                                   |  |  |  | 13c. CITY OR TOWN                                                                                                                                        |  |  |  |
| Maryland                                                                                                                                                                                                                                                                                                                     |  |  |  | Montgomery                                                                                                                                               |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                          |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                                                                               |  |  |  |
| James Ruck                                                                                                                                                                                                                                                                                                                   |  |  |  | Rose Thomas                                                                                                                                              |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                            |  |  |  | 16b. SOCIAL SECURITY NO.                                                                                                                                 |  |  |  |
| No                                                                                                                                                                                                                                                                                                                           |  |  |  | 164-22-2460                                                                                                                                              |  |  |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                                |  |  |  | ADDRESS                                                                                                                                                  |  |  |  |
| Marian B. Ruck Wife                                                                                                                                                                                                                                                                                                          |  |  |  | Same as 13                                                                                                                                               |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                        |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                             |  |  |  |
| IMMEDIATE CAUSE (a) <u>Respiratory failure</u>                                                                                                                                                                                                                                                                               |  |  |  | <u>minutes</u>                                                                                                                                           |  |  |  |
| 1590                                                                                                                                                                                                                                                                                                                         |  |  |  |                                                                                                                                                          |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Widespread metastatic cancer</u>                                                                                                                                                                                                                                                       |  |  |  | <u>18 mo.</u>                                                                                                                                            |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of the bowel</u>                                                                                                                                                                                                                                                             |  |  |  | <u>3 1/2 yrs</u>                                                                                                                                         |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                         |  |  |  |                                                                                                                                                          |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                       |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |  |  |  |
|                                                                                                                                                                                                                                                                                                                              |  |  |  |                                                                                                                                                          |  |  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                            |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                           |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                                                                             |  |  |  |
|                                                                                                                                                                                                                                                                                                                              |  |  |  | P.M. 19                                                                                                                                                  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                                               |  |  |  |                                                                                                                                                          |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK                                                                                                                                                                                                                       |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  |  |  |
|                                                                                                                                                                                                                                                                                                                              |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 80</u> to <u>Oct 7 83</u> , that (I) (we) last saw the deceased alive on <u>10/6/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |                                                                                                                                                          |  |  |  |
| 22b. SIGNATURE OF PHYSICIAN                                                                                                                                                                                                                                                                                                  |  |  |  | 22c. DATE SIGNED                                                                                                                                         |  |  |  |
| <u>Richard P. Delaney MD</u>                                                                                                                                                                                                                                                                                                 |  |  |  | 10/7/83                                                                                                                                                  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                        |  |  |  | 22e. ADDRESS                                                                                                                                             |  |  |  |
| RICHARD P. DELANEY MD                                                                                                                                                                                                                                                                                                        |  |  |  | 4323 HAVARD ST. SIL. SPR 20906                                                                                                                           |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                    |  |  |  | 23b. DATE                                                                                                                                                |  |  |  |
| Burial                                                                                                                                                                                                                                                                                                                       |  |  |  | Oct. 11, 1983                                                                                                                                            |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                                                                                                                                           |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                                                  |  |  |  |
| Gate of Heaven Cemetery                                                                                                                                                                                                                                                                                                      |  |  |  | Silver Spring Mont. Maryland                                                                                                                             |  |  |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                    |  |  |  | 25. DATE REC'D. BY REGISTRAR                                                                                                                             |  |  |  |
| Francis J. Collins                                                                                                                                                                                                                                                                                                           |  |  |  | OCT 13 1983                                                                                                                                              |  |  |  |
| 26. ADDRESS                                                                                                                                                                                                                                                                                                                  |  |  |  | 27. REGISTRAR'S SIGNATURE                                                                                                                                |  |  |  |
| 500 University Blvd., W. Silver Spring, Md.                                                                                                                                                                                                                                                                                  |  |  |  | <u>John J. Conick</u>                                                                                                                                    |  |  |  |

BP

Handwritten notes at the bottom of the page:

Nov 10 1968  
H. J. ...  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

27635

|                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                               |  |                                                                                                                                                             |                       |                                                                                      |                   |                                                                                                                                 |                 |                                                                 |                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|--------------------------------------------------------------------------------------|-------------------|---------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------------------------------------------------------|------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                      |  | 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                           |  | FIRST<br><b>JACK</b>                                                                                                                                        | MIDDLE<br><b>NEIL</b> | LAST<br><b>RYAN</b>                                                                  | 2a. DATE OF DEATH | MONTH<br><b>OCT</b>                                                                                                             | DAY<br><b>5</b> | YEAR<br><b>1983</b>                                             | 2b. HOUR<br><b>9:27 P.M.</b> |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>WHITE</b>                                                                                                                       |  | 5. DATE OF BIRTH<br>MONTH <b>July</b> DAY <b>10</b> YEAR <b>1929</b>                                                                                        |                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b>                                         |                   | IF UNDER 1 YEAR<br>MONTHS <b>YRS.</b> DAYS <b>MIN.</b>                                                                          |                 | IF UNDER 24 HRS.                                                |                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Missouri</b>                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                        |                   |                                                                                                                                 |                 |                                                                 |                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>TAKOMA PARK</b>                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hosp</b> |  | 12a. USUAL OCCUPATION<br>(IF DECEASED FOR MOST OF WORKING LIFE)<br><b>Produce Manager</b>                                                                   |                       | 12b. BUSINESS OR INDUSTRY<br><b>Food Store</b>                                       |                   |                                                                                                                                 |                 |                                                                 |                              |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY<br><b>Prince Geo. Hills</b>                                                                                                       |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |                       | 13d. STREET ADDRESS<br><b>4609 72nd Avenue 20784</b>                                 |                   |                                                                                                                                 |                 |                                                                 |                              |  |
| 14. FATHER'S NAME<br>FIRST <b>Ira</b> MIDDLE <b>Ryan</b> LAST <b>Wheatley</b>                                                                                                                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Bertha</b> MIDDLE <b>Wheatley</b> LAST <b>Wheatley</b>                                                   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>                                                                              |                       | 16b. SOCIAL SECURITY NO.<br><b>579-36-4131</b>                                       |                   | 17. INFORMANT<br><b>Ruth H. Ryan</b>                                                                                            |                 | ADDRESS<br><b>Same as #13 (Wife)</b>                            |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>3334</b> IMMEDIATE CAUSE (a) <b>RESPIRATORY Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HUNTINGTON'S CHOREA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>17 yrs.</b>                               |  |                                                                                                                                               |  |                                                                                                                                                             |                       |                                                                                      |                   |                                                                                                                                 |                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 hr.</b> |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>                                                                                                                                                                                         |  |                                                                                                                                               |  |                                                                                                                                                             |                       |                                                                                      |                   |                                                                                                                                 |                 |                                                                 |                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                              |  |                                                                                                                                                             |                       | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                 |                                                                 |                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                       |                                                                                      |                   |                                                                                                                                 |                 |                                                                 |                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                       |                                                                                      |                   |                                                                                                                                 |                 |                                                                 |                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3 Oct 83</b> , to <b>5 Oct 83</b> , that (I) (we) last saw the deceased alive on <b>3 Oct 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death. |  |                                                                                                                                               |  |                                                                                                                                                             |                       |                                                                                      |                   |                                                                                                                                 |                 |                                                                 |                              |  |
| 22b. SIGNATURE<br><b>Walter E. Goozh, M.D.</b> DEGREE                                                                                                                                                                                                                                                                             |  |                                                                                                                                               |  |                                                                                                                                                             |                       |                                                                                      |                   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                 | 22c. DATE SIGNED<br><b>Oct 6, 1983</b>                          |                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WALTER E. GOOZH, M.D.</b>                                                                                                                                                                                                                                                             |  |                                                                                                                                               |  |                                                                                                                                                             |                       |                                                                                      |                   | 22e. ADDRESS<br><b>2309 Shorefield Dr. Wheaton M.D.</b>                                                                         |                 |                                                                 |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br><b>10/11/83</b>                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Resurrection Cemetery</b>                                                                                          |                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Clinton P.G. Maryland</b>           |                   |                                                                                                                                 |                 |                                                                 |                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>GASeh Funeral Home Hyattsville Md.</b> ADDRESS                                                                                                                                                                                                                                                 |  |                                                                                                                                               |  |                                                                                                                                                             |                       | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 13 1983</b>                                  |                   | 25b. REGISTRAR'S SIGNATURE<br><b>Jan J. Connel</b>                                                                              |                 |                                                                 |                              |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                  |  |                                                                                                                                       |  | REG. NO.                                                                                                                                                    |  |                                                                                                                               |                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Marie M. Ryan</b>                                                                                                                                                                                                                                                                                              |  |                                                                                                                                       |  | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>24</b> YEAR <b>1983</b>                                                                                         |  |                                                                                                                               |                                                               |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br><b>White</b>                                                                                                               |  | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>11</b> YEAR <b>04</b>                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.                                                                             |                                                               |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>New Jersey</b>                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                                                 |                                                               |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>retired</b>                                                                          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Army Signal Corps</b>                                                                 |                                                               |
| 13a. STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                       |  | 13b. COUNTY<br><b>MONT.</b>                                                                                                                                 |  | 13c. CITY OR TOWN<br><b>ROCKVILLE</b>                                                                                         |                                                               |
| 14. FATHER'S NAME<br>FIRST <b>Michael</b> MIDDLE <b>Lenihan</b> LAST <b>Michael</b>                                                                                                                                                                                                                                                                   |  |                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Bridgett</b> MIDDLE <b>Kehoe</b> LAST <b>Kehoe</b>                                                                     |  |                                                                                                                               |                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>                                                                                                                                                                                                                                                                        |  |                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br><b>578 18 1975</b>                                                                                                              |  | 17. INFORMANT<br><b>Wharton, N.J. 07885</b><br><b>Claire M. Jordan 66 Richard Mine Rd.</b>                                    |                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas</b><br><b>1579</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                            |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2mo</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                    |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                               |                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                               |                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                               |                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/25</b> , 19____, to <b>10/24/83</b> , 19____, that (I) (we) last saw the deceased alive on <b>10/24/83</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                               |                                                               |
| 22b. SIGNATURE<br><b>Jeremy V. Cooke</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                       |  | DEGREE<br><b>M7</b>                                                                                                                                         |  | 22c. DATE SIGNED<br><b>10/25/83</b>                                                                                           |                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jeremy Cooke</b>                                                                                                                                                                                                                                                                                          |  |                                                                                                                                       |  | 22e. ADDRESS<br><b>10400 Con n. Ave. Kensington, Md.</b>                                                                                                    |  |                                                                                                                               |                                                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><b>10/29/83</b>                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cemetery</b>                                                                                        |  | 23d. LOCATION<br>CITY OR TOWN <b>Silver Spring</b> COUNTY <b>Maryland</b> STATE                                               |                                                               |
| 24. FUNERAL DIRECTOR<br><b>Pyson Wheeler Funeral Home, Inc.</b><br><b>1331 Rockville Pike Rockville, Maryland 20852</b>                                                                                                                                                                                                                               |  |                                                                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 28 1983</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>                                                                           |                                                               |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 and 5 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                      |                                                 |                                                                                                                                                             |  |                                                                                                                           |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Martha Liebmann Sagior                                                                                                                                                                                                                                        |  |                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 28 83 |                                                                                                                                                             |  | 2b. HOUR<br>4:40 P.M.                                                                                                     |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                     |  | 4. RACE<br>Caucasian                                                                                                                 |                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 12 11                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.                                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>AUSTRIA                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                               |                                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                                                             |  |
| 10. CITY OR TOWN OF DEATH<br>Wheaton                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Nursing Home |                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>OWN HOME                                                                             |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                    |  |                                                                                                                                      |                                                 | 13b. COUNTY<br>Montgomery                                                                                                                                   |  | 13c. CITY OR TOWN<br>Kensington                                                                                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>OTTO                                                                                                                                                                                                                                                       |  |                                                                                                                                      |                                                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>IDA                                                                                                        |  |                                                                                                                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>233-40-9055                                                               |                                                 | 17. INFORMANT<br>ADDRESS<br>10900 Devin Place KENSINGTON, MD.<br>JAMES SAGIOR - HUSBAND<br>20895                                                            |  |                                                                                                                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 2773 Primary Amyloidosis<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 1/2 YEARS |  |                                                                                                                                      |                                                 |                                                                                                                                                             |  |                                                                                                                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                  |  |                                                                                                                                      |                                                 |                                                                                                                                                             |  |                                                                                                                           |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSE OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                           |                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                           |  |
| 22a. I certify that (1) (the medical) attended the deceased from October 1982, to 10/28/83, that (1) (was) lost saw the deceased alive on 10/26/83, and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I have) (did not) view the body after death. |  |                                                                                                                                      |                                                 |                                                                                                                                                             |  |                                                                                                                           |  |
| 22b. SIGNATURE<br>DE SHAND M.D.                                                                                                                                                                                                                                                                      |  |                                                                                                                                      |                                                 | DEGREE<br>M.D.                                                                                                                                              |  | 22c. DATE SIGNED<br>10/28/83                                                                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DENNIS J. HAND M.D.                                                                                                                                                                                                                                         |  |                                                                                                                                      |                                                 | 22e. ADDRESS<br>4600 CONNECTICUT AVE. N.W.<br>WASHINGTON DC 20008                                                                                           |  |                                                                                                                           |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION                                                                                                                                                                                                                                            |  | 23b. DATE<br>OCT. 29, 1983                                                                                                           |                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br>METROPOLITAN CREMATORY                                                                                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ALEXANDRIA VIRGINIA                                                         |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>FRANCIS J. COLLINS                                                                                                                                                                                                                                                   |  |                                                                                                                                      |                                                 | 25a. DATE REC'D. BY REGISTRAR<br>NOV 2 1983                                                                                                                 |  | 25b. REGISTRAR'S SIGNATURE                                                                                                |  |
| 500 UNIVERSITY BLVD. W. SILVER SPRING, MD.                                                                                                                                                                                                                                                           |  |                                                                                                                                      |                                                 |                                                                                                                                                             |  |                                                                                                                           |  |



2025 COLLECTION LINE

2025 COLLECTION LINE

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                    |  |                                                                                                                                    |                                                            |                                                                                                                                                             |  |                                                                                                 |  |                                                                |  |
|------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GEORGE LEE SALYER</b>                    |  |                                                                                                                                    | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>OCTOBER 26 1983</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>8:15 a</b>                                                                       |  |                                                                |  |
| 3. SEX<br><b>MALE</b>                                                              |  | 4. RACE<br><b>CAUCASIAN</b>                                                                                                        |                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH 18 1927</b>                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS                                                |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>0 0 0 0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>KANSAS</b>                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>                                                                               |                                                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD                                    |  |                                                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NAVAL HOSPITAL</b> |                                                            |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. NAVY</b>          |  |
| 13a. STATE<br><b>VIRGINIA</b>                                                      |  | 13b. COUNTY<br><b>FAIRFAX</b>                                                                                                      |                                                            | 13c. CITY OR TOWN<br><b>SPRINGFIELD</b>                                                                                                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5716 ANOLA COURT</b>                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES SALYER</b>                    |  |                                                                                                                                    |                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELLA POTWIN</b>                                                                                         |  |                                                                                                 |  |                                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>1942-1967</b>                                                        |                                                            | 17. INFORMANT<br><b>ELSIE SALYER</b>                                                                                                                        |  | ADDRESS<br><b>5716 ANOLA COURT, SPRINGFIELD, VA</b>                                             |  |                                                                |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **SQUAMOUS CELL CARCINOMA OF THE LUNG WIDELY METASTATIC**

1629

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                        |  |                                                                                                               |  |                                                                                                                                          |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                |  |                                                                                                                                          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                             |  |                                                                                                                                          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 22, 1983</b> , to <b>OCTOBER 26, 1983</b> , that (I) (we) last<br>saw the deceased alive on <b>OCTOBER 26, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                               |  |                                                                                                                                          |  |
| 22b. SIGNATURE<br><i>Richard Erwin McVern</i>                                                                                                                                                                                                                                                                                                                   |  |                                                                        |  | DEGREE<br><b>MD</b>                                                                                           |  | 22c. DATE SIGNED<br><b>10/26/83</b>                                                                                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD ERWIN, LT, MC, USNR</b>                                                                                                                                                                                                                                                                                     |  |                                                                        |  | 22e. ADDRESS<br><b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,<br/>NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b> |  |                                                                                                                                          |  |

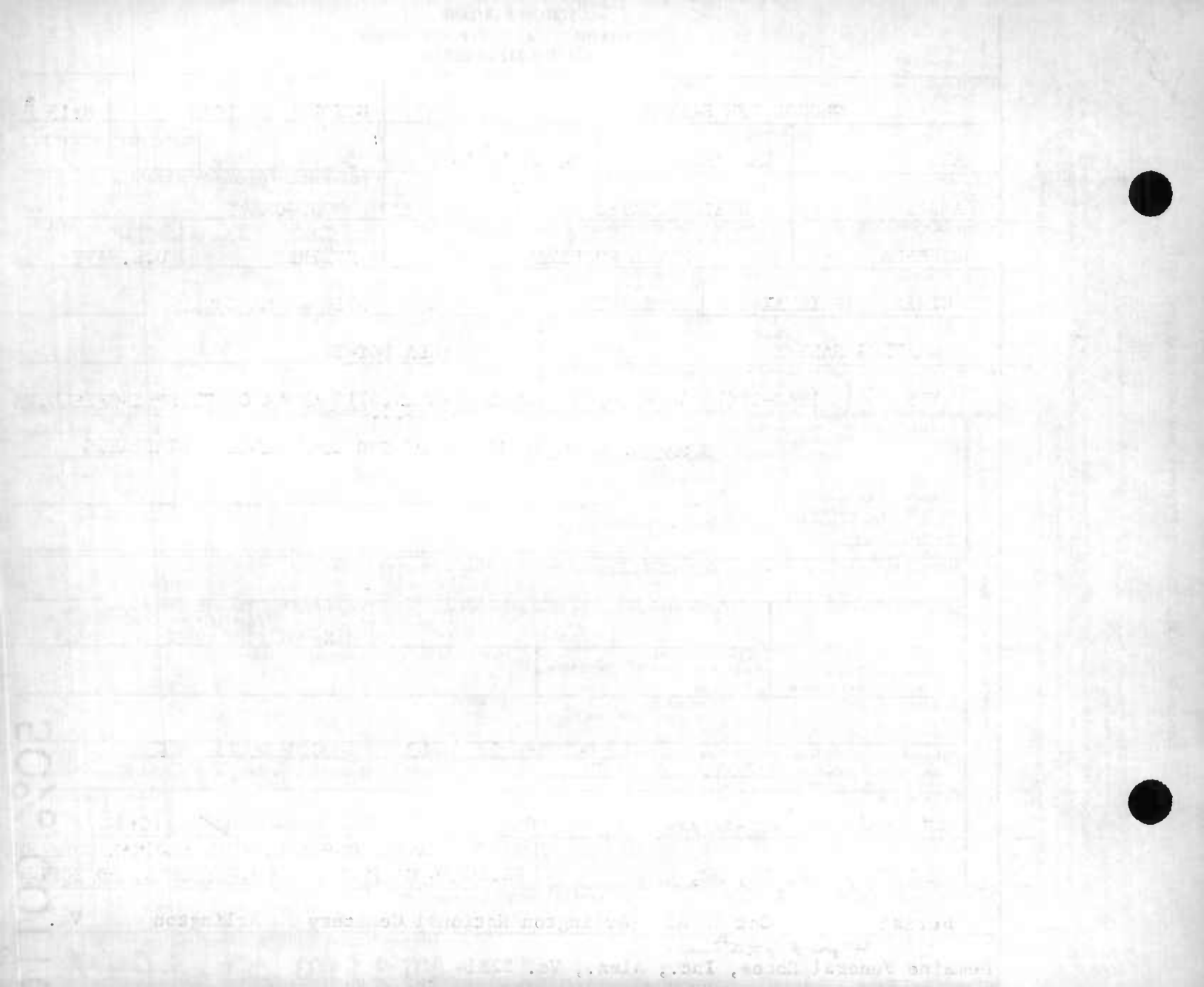
|                                                                    |  |                               |  |                                                                          |  |                                                                    |  |
|--------------------------------------------------------------------|--|-------------------------------|--|--------------------------------------------------------------------------|--|--------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>      |  | 23b. DATE<br><b>Oct 28 83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlington Va.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Demaine Funeral Homes, Inc.</i> |  |                               |  | ADDRESS<br><b>Alex., Va. 22314</b>                                       |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 31 1983</b>                |  |
|                                                                    |  |                               |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Carver</i>                      |  |                                                                    |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                          |     |                                                                                   |          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-----------------------------------------------------------------------------------|----------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                |  | 2a. DATE OF DEATH                                                                                                                                                                                                                                                                                                                                          |  | MONTH                                                                                                                                                    | DAY | YEAR                                                                              | 2b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                      |  | 3. SEX                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE                                                                                                                                                  |     | 5. DATE OF BIRTH                                                                  |          |
| Francis MARIA LEONIE Sarrault                                                                                                                                                                                                                                                                                         |  | FEMALE                                                                                                                                                                                                                                                                                                                                                     |  | WHITE                                                                                                                                                    |     | MARCH 24, 1897                                                                    |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |     | 9. BALTIMORE CITY OR COUNTY OF DEATH                                              |          |
| NEW CALEDONIA                                                                                                                                                                                                                                                                                                         |  | FRANCE                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                          |     | Montgomery MD.                                                                    |          |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                                                                                                                                                                                                                                     |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |     | 12b. KIND OF BUSINESS OR INDUSTRY                                                 |          |
| Bethesda                                                                                                                                                                                                                                                                                                              |  | Suburban Hospital                                                                                                                                                                                                                                                                                                                                          |  | HOUSEWIFE                                                                                                                                                |     | AT HOME                                                                           |          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                          |  | 13b. COUNTY                                                                                                                                                                                                                                                                                                                                                |  | 13c. CITY OR TOWN                                                                                                                                        |     | 13d. INSIDE CITY LIMITS?                                                          |          |
| Md.                                                                                                                                                                                                                                                                                                                   |  | MONTGOMERY                                                                                                                                                                                                                                                                                                                                                 |  | KENSINGTON                                                                                                                                               |     | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |          |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                        |     | 16b. SOCIAL SECURITY NO.                                                          |          |
| UNKNOWN                                                                                                                                                                                                                                                                                                               |  | BRINI                                                                                                                                                                                                                                                                                                                                                      |  | FANNY                                                                                                                                                    |     | 578-74-6891                                                                       |          |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                         |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                  |  | 19a. DATE OF OPERATION                                                                                                                                   |     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                  |          |
| NICOLE NEWMAN                                                                                                                                                                                                                                                                                                         |  | PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>septicemia</u><br>5990<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>urinary tract infection</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>generalized arteriosclerosis, rheumatoid arthritis</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day</u><br><u>1 week</u>                                                                            |     | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                    |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                                                                                                                                                                                                                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                           |     | 22a. SIGNATURE                                                                    |          |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                |  | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                                        |  | 21c. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |     | 22b. PHYSICIAN'S NAME (TYPE OR PRINT)                                             |          |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>January 1972</u> to <u>October 1983</u> , that (I) (we) saw the deceased alive on <u>Oct 1 1983</u> , and that in my opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  | 22b. SIGNATURE <u>Marvin Wadler</u>                                                                                                                                                                                                                                                                                                                        |  | 22c. DATE SIGNED <u>Oct. 2, 1983</u>                                                                                                                     |     | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                             |          |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                        |  | 22c. DATE SIGNED                                                                                                                                                                                                                                                                                                                                           |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                    |     | 22e. ADDRESS                                                                      |          |
| MARVIN WADLER                                                                                                                                                                                                                                                                                                         |  | OCT. 2, 1983                                                                                                                                                                                                                                                                                                                                               |  | MARVIN WADLER                                                                                                                                            |     | 8218 Wisc. Av. Beth., 20814 Md.                                                   |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                             |  | 23b. DATE                                                                                                                                                                                                                                                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |     | 23d. LOCATION CITY OR TOWN COUNTY STATE                                           |          |
| CREMATION                                                                                                                                                                                                                                                                                                             |  | 10-3-1983                                                                                                                                                                                                                                                                                                                                                  |  | CEDAR HILL CREM.                                                                                                                                         |     | SWITZLAND P.C. Md.                                                                |          |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                                                                                                                                                                                                                              |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                               |     | 25c. DATE REC'D. BY REGISTRAR                                                     |          |
| W. W. CHAMBERS CO. INC.                                                                                                                                                                                                                                                                                               |  | OCT 4 1983                                                                                                                                                                                                                                                                                                                                                 |  | John J. Connel                                                                                                                                           |     | OCT 4 1983                                                                        |          |



10% COLLECT

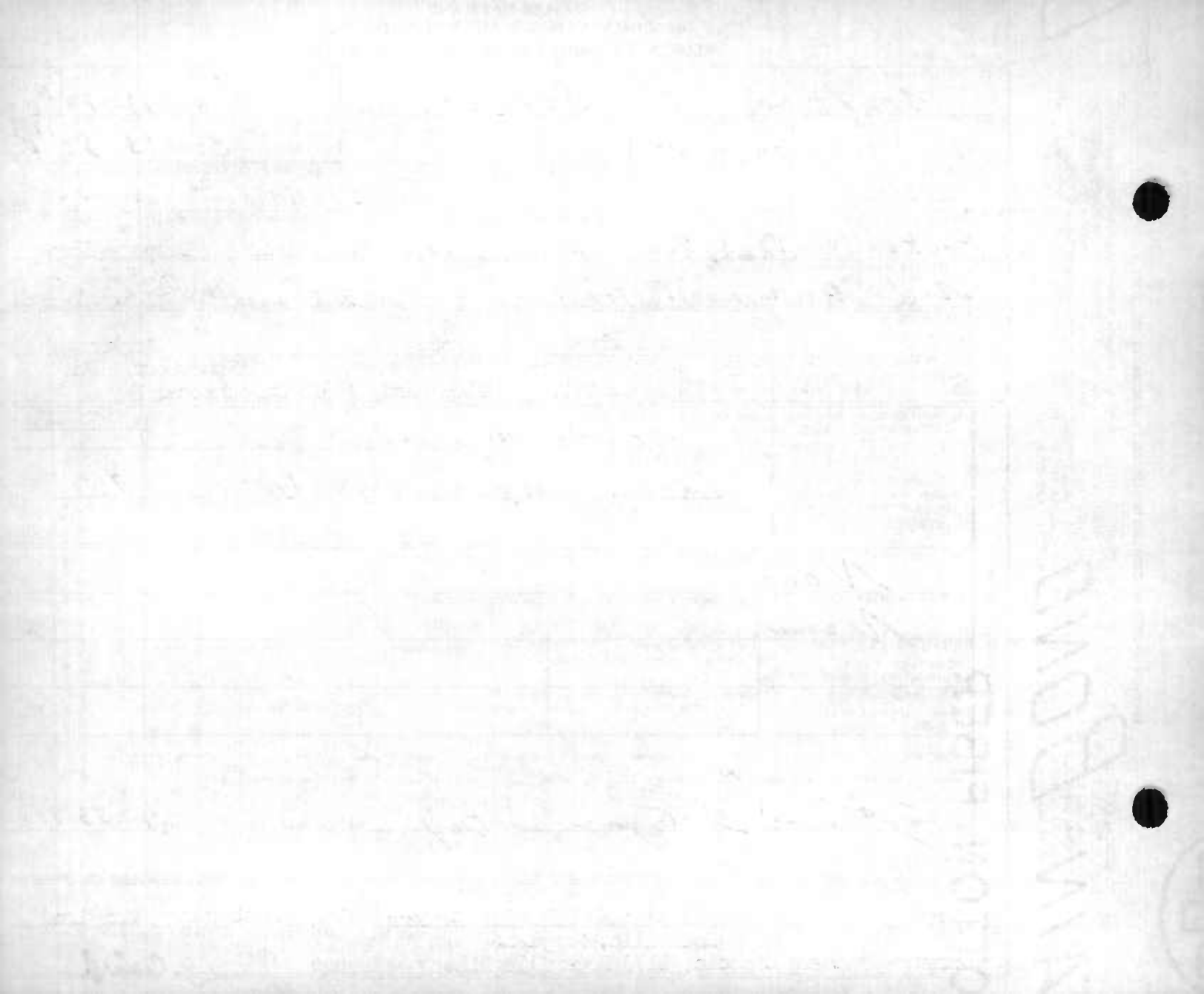
10% COLLECT

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                  |  |                  |  |                                                                                                                                              |  |                                                     |  |                                                                                                                                                             |  | 27841<br>REG. NO.                                            |  |                                                           |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------|--|-----------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Milton J. Schachman</u>                                                                                                                                                                                                                                                                                                                                                                                                           |  |                  |  |                                                                                                                                              |  |                                                     |  |                                                                                                                                                             |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <u>6-23-1983</u>        |  | 2b. HOUR <u>8:00</u> P.M.                                 |  |
| 3. SEX <u>M</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE <u>W</u> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <u>Jan. 5, 1923</u>                                                                                       |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <u>60</u> YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN                                                                                                                     |  | 7c. DATE PRONOUNCED DEAD<br><u>Oct 23, 1983</u>              |  | 7d. HOUR <u>1:00</u> P.M.                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>New Jersey</u>                                                                                                                                                                                                                                                                                                                                                                                                           |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                                                   |  |                                                     |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Montgomery</u> MD |  |                                                           |  |
| 10. CITY OR TOWN OF DEATH<br><u>Rockville</u>                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Shady Grove Advent Hosp</u> |  |                                                     |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Supervisor</u>                                                                          |  |                                                              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Drapery Shop</u>  |  |
| 13a. STATE <u>MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                  |  | 13b. COUNTY <u>Montgomery</u>                                                                                                                |  | 13c. CITY OR TOWN <u>Cathetersburg</u>              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13e. STREET ADDRESS<br><u>18915 Smoothstone Way</u>          |  |                                                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Isador Schachman</u>                                                                                                                                                                                                                                                                                                                                                                                                        |  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Rose (unknown)</u>                                                                       |  |                                                     |  | 16. SOCIAL SECURITY NO.<br><u>136-12-6392</u>                                                                                                               |  |                                                              |  | 17. INFORMANT<br><u>Helen Hess; 18915 Smoothstone Way</u> |  |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><u>No</u>                                                                                                                                                                                                                                                                                                                                                                                       |  |                  |  | 18b. SOCIAL SECURITY NO.<br><u>136-12-6392</u>                                                                                               |  |                                                     |  | 18c. DATE OF DEATH<br><u>6-23-1983</u>                                                                                                                      |  |                                                              |  | 18d. TIME OF DEATH<br><u>1:00</u>                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><u>4291</u> IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <u>Chronic Myocardial Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Yrs.</u> |  |                  |  |                                                                                                                                              |  |                                                     |  |                                                                                                                                                             |  |                                                              |  |                                                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>None</u>                                                                                                                                                                                                                                                                                                                        |  |                  |  |                                                                                                                                              |  |                                                     |  |                                                                                                                                                             |  |                                                              |  |                                                           |  |
| 19a. DATE OF OPERATION<br><u>None</u>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><u>None</u>                                                                             |  |                                                     |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                         |  |                                                              |  |                                                           |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>                                                                            |  |                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                              |  |                                                           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                           |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                  |  |                                                     |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                                                  |  |                                                              |  |                                                           |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .                   |  |                  |  |                                                                                                                                              |  |                                                     |  |                                                                                                                                                             |  |                                                              |  |                                                           |  |
| ACTUAL SIGNATURE<br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                  |  | TITLE (SPECIFY)<br>M.D. <u>Doc</u>                                                                                                           |  |                                                     |  | MEDICAL EXAMINER<br>DATE SIGNED <u>6-23-1983</u>                                                                                                            |  |                                                              |  |                                                           |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                  |  | ADDRESS                                                                                                                                      |  |                                                     |  |                                                                                                                                                             |  |                                                              |  |                                                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                               |  |                  |  | 23b. DATE<br><u>10-25-1983</u>                                                                                                               |  |                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Judean Memorial Gardens</u>                                                                                        |  |                                                              |  |                                                           |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Olney; Montgomery, Maryland</u>                                                                                                                                                                                                                                                                                                                                                                                         |  |                  |  | 23e. DATE REC'D. BY REGISTRAR                                                                                                                |  |                                                     |  | 23f. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                                                                                            |  |                                                              |  |                                                           |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>Danzansky-Goldberg Chapels; 1170 Rockville Pike</u> ADDRESS <u>Rockville, Maryland</u>                                                                                                                                                                                                                                                                                                                                                   |  |                  |  |                                                                                                                                              |  |                                                     |  |                                                                                                                                                             |  |                                                              |  |                                                           |  |

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OCT 28 1983



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                            |  |                                                                                                                                                             |                  |                                                                                                                                            |  |                                                                                                                            |           |                                                                                      |                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|-----------|--------------------------------------------------------------------------------------|---------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | FIRST<br>Hazel                                                                                                                             |  | MIDDLE<br>M.                                                                                                                                                | LAST<br>Schlauch | 2a. DATE OF DEATH                                                                                                                          |  | MONTH<br>10                                                                                                                | DAY<br>18 | YEAR<br>83                                                                           | 2b. HOUR<br>4:10 AM |
| 3. SEX<br>7                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br>W                                                                                                                               |  | 5. DATE OF BIRTH<br>MONTH 1 DAY 9 YEAR 98                                                                                                                   |                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.                                                                                                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                             |           | IF UNDER 24 HRS<br>HOURS MIN.                                                        |                     |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Indiana                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                        |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                                                                                     |  |                                                                                                                            |           |                                                                                      |                     |
| 10. CITY OR TOWN OF DEATH<br>Takoma Park                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Washington Adventist Hospital |  |                                                                                                                                                             |                  |                                                                                                                                            |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                                              |           | 12b. KIND OF BUSINESS OR INDUSTRY                                                    |                     |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                            |  |                                                                                                                                                             |                  | 13b. COUNTY<br>PG                                                                                                                          |  | 13c. CITY OR TOWN<br>Lewisdale                                                                                             |           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jerry Ramsey                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                            |  |                                                                                                                                                             |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ella Skillman                                                                             |  |                                                                                                                            |           |                                                                                      |                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>None                                                                                                                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br>577 34 3480                                                                                                    |  | 17. INFORMANT<br>5913 89th Ave. New Carrollton<br>Donald Schlauch (Son) Maryland                                                                            |                  |                                                                                                                                            |  |                                                                                                                            |           |                                                                                      |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Congestive Heart Failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arteriosclerotic Heart Disease</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2-3 hrs |  |                                                                                                                                            |  |                                                                                                                                                             |                  |                                                                                                                                            |  |                                                                                                                            |           |                                                                                      |                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                            |  |                                                                                                                                                             |                  |                                                                                                                                            |  |                                                                                                                            |           |                                                                                      |                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                           |  |                                                                                                                                                             |                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |           |                                                                                      |                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                  |                                                                                                                                            |  |                                                                                                                            |           |                                                                                      |                     |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                  |                                                                                                                                            |  |                                                                                                                            |           |                                                                                      |                     |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MAY</u> 19 <u>63</u> , to <u>OCT 18</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>OCT 17</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (I) did not view the body after death.                                                                                                                              |  |                                                                                                                                            |  |                                                                                                                                                             |                  |                                                                                                                                            |  |                                                                                                                            |           |                                                                                      |                     |
| 22b. SIGNATURE<br><u>Robert B. Frey</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                            |  | DEGREE<br>MD                                                                                                                                                |                  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>10-18-83                                                                                               |           |                                                                                      |                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert B. Frey                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                            |  | 22e. ADDRESS<br>1161 New Hampshire Ave, Silver Spring Md                                                                                                    |                  |                                                                                                                                            |  |                                                                                                                            |           |                                                                                      |                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br>10/20/83                                                                                                                      |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Ft. Lincoln                                                                                                           |                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brentwood PG Maryland                                                                        |  |                                                                                                                            |           |                                                                                      |                     |
| 24. FUNERAL DIRECTOR<br>Hines/Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring, Md.                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                            |  |                                                                                                                                                             |                  |                                                                                                                                            |  |                                                                                                                            |           |                                                                                      |                     |
| 25a. DATE REC'D. BY REGISTRAR<br>25b. REGISTRAR'S SIGNATURE<br><u>John J. Smith</u>                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                            |  |                                                                                                                                                             |                  |                                                                                                                                            |  |                                                                                                                            |           |                                                                                      |                     |



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CHIEFMAN

200111

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                               |                                                                        |                                                                                                                                                            |                                                                          |                                                                                                |                                                                                                 |                                                                                                                            |                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Edward C Schmerber</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 30, 1983</b>         |                                                                                                                                                            |                                                                          | 2b. HOUR<br><b>8:15p M</b>                                                                     |                                                                                                 |                                                                                                                            |                                                                            |  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4 RACE<br><b>Caucasian</b>                                                                                                                    |                                                                        | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 3, 1904</b>                                                                                                |                                                                          | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b><br>YRS MONTHS DAYS                                 |                                                                                                 | IF UNDER 1 YEAR<br>IF UNDER 74 HRS<br>HOURS MIN.                                                                           |                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                          |                                                                        | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                          | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD</b>                             |                                                                                                 |                                                                                                                            |                                                                            |  |
| 10 CITY OR TOWN OF DEATH<br><b>Rockville</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Collingswood Nursing Home</b> |                                                                        |                                                                                                                                                            |                                                                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Underground Foreman</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY (P.S.E.G.)<br><b>Utility</b>                                                             |                                                                            |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                               | 13b. COUNTY<br><b>Montgomery</b>                                       |                                                                                                                                                            | 13c. CITY OR TOWN<br><b>Potomac</b>                                      |                                                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br><b>9424 Wooden Bridge Road</b><br>Zip: <b>20854</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Not Available</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                               | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Not Available</b>   |                                                                                                                                                            |                                                                          |                                                                                                |                                                                                                 |                                                                                                                            |                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                               | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N.A.</b> |                                                                                                                                                            | 17. INFORMANT (Wife)<br><b>Margaret Carey Schmerber, Rd. Potomac, MD</b> |                                                                                                | ADDRESS <b>9424 Wooden Bridge</b>                                                               |                                                                                                                            |                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>pulmonary embolism</b><br><b>1533</b><br>DUE TO OR AS A CONSEQUENCE OF<br>(b) <b>abdominal resection sigmoid</b><br>DUE TO OR AS A CONSEQUENCE OF<br>(c) <b>Carcinoma of the sigmoid colon</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 min</b><br><b>26 d</b><br><b>unk</b> |  |                                                                                                                                               |                                                                        |                                                                                                                                                            |                                                                          |                                                                                                |                                                                                                 |                                                                                                                            |                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                              |  |                                                                                                                                               |                                                                        |                                                                                                                                                            |                                                                          |                                                                                                |                                                                                                 |                                                                                                                            |                                                                            |  |
| 19a. DATE OF OPERATION<br><b>10/4/83</b>                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Ca colon</b>    |                                                                                                                                                            |                                                                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                         |  |                                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |                                                                                                                                                            |                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                 |                                                                                                 |                                                                                                                            |                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                            |                                                                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                              |                                                                                                 |                                                                                                                            |                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>82</b> , to <b>10/30</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>10/29/</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                                                                 |  |                                                                                                                                               |                                                                        |                                                                                                                                                            |                                                                          |                                                                                                |                                                                                                 |                                                                                                                            |                                                                            |  |
| 22b. SIGNATURE<br><b>Lewis N. Cahill M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                               |                                                                        |                                                                                                                                                            |                                                                          | DEGREE                                                                                         |                                                                                                 | 22c. DATE SIGNED<br><b>Oct 31, 1983</b>                                                                                    |                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lewis N. Cahill, M.D.</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                               |                                                                        |                                                                                                                                                            |                                                                          | 22e. ADDRESS<br><b>#202A<br/>5411 Cedar Lane, Bethesda, Maryland</b>                           |                                                                                                 |                                                                                                                            |                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                               | 23b. DATE<br><b>Nov. 3, 1983</b>                                       |                                                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Restland Memorial Park</b>      |                                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>East Hanover, Morris, N.J.</b>                 |                                                                                                                            |                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey Funeral Homes, P.A., 7557 Wisconsin Ave., Bethesda, MD</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               |                                                                        |                                                                                                                                                            |                                                                          | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 4 1983</b>                                             |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Cahill</b>                                                                        |                                                                            |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                         |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                             |                                                                        |                                                                                                                                                             | REG. NO.                                                                                        |                                                                                      |                                                                         |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNA K. SCHMITZ</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                             |                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 1-1983</b>                                    |                                                                                      |                                                                         | 2b. HOUR<br>4:25 A.M.                                                                                                      |  |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>CAUCASIAN</b>                                                                                                                 |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 21 05</b>                                                                                                        |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.                                    |                                                                         | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>GERMANY</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                  |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                        |                                                                         |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>WNEATON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY NURSING HOME</b> |                                                                        |                                                                                                                                                             |                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |                                                                         | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                             |                                                                        |                                                                                                                                                             | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                      |                                                                         |                                                                                                                            |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY<br><b>Mont.</b>                                                                                                                 |                                                                        | 13c. CITY OR TOWN<br><b>S.S.</b>                                                                                                                            |                                                                                                 | 13d. STREET ADDRESS<br><b>20901 217 University Blvd.W.</b>                           |                                                                         |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Fridolin Schlatterer</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                             |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Telling</b>                            |                                                                                      |                                                                         |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br><b>None</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                             |                                                                        |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br><b>215 46 2848</b>                                                  |                                                                                      | 17. INFORMANT<br>ADDRESS<br><b>Same as 13E Ernest Schmitz (Husband)</b> |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b><br><b>1889</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Carcinoma of bladder</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>36 hours</b><br><b>2 years</b> |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                         |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                         |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                                                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |                                                                                      |                                                                         |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                      |                                                                         |                                                                                                                            |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>Jan. 28</b> 19 <b>82</b> , to <b>Oct 1</b> 19 <b>83</b> , that (he) (we) last saw the deceased alive on <b>Oct. 1</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                         |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Raymond Bradshaw, MD</b> DEGREE                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                             |                                                                        |                                                                                                                                                             | 22c. DATE SIGNED<br><b>Oct. 1, 1983</b>                                                         |                                                                                      |                                                                         | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Raymond Bradshaw MD.</b>                                                       |  |
| 22e. ADDRESS<br><b>345 University Blvd, W<br/>Silver Spring, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                         |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br><b>10/3/83</b>                                                                                                                 |                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Kensico Cemetery</b>                                                                                               |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Mt. Pleasant, New York</b>          |                                                                         |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br><b>Hines/Rinaldi</b> ADDRESS<br><b>11800 New Hampshire Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                             |                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT. 4 - 1983</b>                                           |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>                     |                                                                                                                            |  |



WILSON

NO. 100

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3, 4, 5, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |         |                   |                                                             |  |                                    |  |                                                                                                                                                          |                |                                    |  |                                                                     |  |                                              |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------|-------------------|-------------------------------------------------------------|--|------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------|--|---------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                      |  |         | FIRST MIDDLE LAST |                                                             |  | 2a. DATE KNOWN OF DEATH            |  |                                                                                                                                                          | MONTH DAY YEAR |                                    |  | 7b. HOUR                                                            |  |                                              |  |
| Herbert Martin Schneider                                                                                                                                                                                                                                                                                                                                                                                                                 |  |         |                   |                                                             |  | 10/7 1983                          |  |                                                                                                                                                          |                |                                    |  | M                                                                   |  |                                              |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE |                   | 5. DATE OF BIRTH                                            |  | 6. AGE (IN YEARS)                  |  | IF UNDER 1 YR.                                                                                                                                           |                | IF UNDER 24 HRS.                   |  | 7c. DATE PRONOUNCED DEAD                                            |  | 7d. HOUR                                     |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | White   |                   | Aug. 17, 1902                                               |  | 81 YRS.                            |  |                                                                                                                                                          |                |                                    |  | 10/10/1983                                                          |  | 5:10 P. M.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                |  |         |                   | 7b. CITIZEN OF WHAT COUNTRY?                                |  |                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                |                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                              |  |
| WI                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |         |                   | US.A.                                                       |  |                                    |  |                                                                                                                                                          |                |                                    |  | Montgomery County MD                                                |  |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                |  |         |                   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  |                                    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |                |                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                              |  |
| Silver Spring                                                                                                                                                                                                                                                                                                                                                                                                                            |  |         |                   | 15310 Pine Orchard Drive, #3                                |  |                                    |  | Life Ins.                                                                                                                                                |                |                                    |  | Insurance                                                           |  |                                              |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                               |  |         |                   | 13b. COUNTY                                                 |  | 13c. CITY OR TOWN                  |  | 13d. INSIDE CITY LIMITS?                                                                                                                                 |                | 13e. STREET ADDRESS                |  |                                                                     |  |                                              |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |         |                   | Montgomery                                                  |  | Silver Spring                      |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                 |                | 20906 15310 Pine Orchard Drive, #3 |  |                                                                     |  |                                              |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                        |  |         |                   | 15. MOTHER'S MAIDEN NAME                                    |  |                                    |  |                                                                                                                                                          |                |                                    |  |                                                                     |  |                                              |  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                        |  |         |                   | FIRST MIDDLE LAST                                           |  |                                    |  |                                                                                                                                                          |                |                                    |  |                                                                     |  |                                              |  |
| Edward C. Schneider                                                                                                                                                                                                                                                                                                                                                                                                                      |  |         |                   | Christiane Wichmann                                         |  |                                    |  |                                                                                                                                                          |                |                                    |  |                                                                     |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                                                                                                                                                                                                                                                                                                                                                                             |  |         |                   | 16b. SOCIAL SECURITY NO.                                    |  |                                    |  | 17. INFORMANT ADDRESS                                                                                                                                    |                |                                    |  |                                                                     |  |                                              |  |
| (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                                                    |  |         |                   | (IF YES, GIVE WAR OR DATES)                                 |  |                                    |  | 389-01-9777                                                                                                                                              |                |                                    |  | Kathryne Jean Smith 3149 Wash., D.C. 20008 Newark St. N.W.          |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                                |  |         |                   |                                                             |  |                                    |  |                                                                                                                                                          |                |                                    |  |                                                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                                                              |  |         |                   |                                                             |  |                                    |  |                                                                                                                                                          |                |                                    |  |                                                                     |  |                                              |  |
| IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u>                                                                                                                                                                                                                                                                                                                                                                                      |  |         |                   |                                                             |  |                                    |  |                                                                                                                                                          |                |                                    |  |                                                                     |  |                                              |  |
| 4029                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |         |                   |                                                             |  |                                    |  |                                                                                                                                                          |                |                                    |  |                                                                     |  |                                              |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                                                                                                                                                                                                                                                                                            |  |         |                   |                                                             |  |                                    |  |                                                                                                                                                          |                |                                    |  |                                                                     |  |                                              |  |
| (b) <u>hypertensive heart disease.</u>                                                                                                                                                                                                                                                                                                                                                                                                   |  |         |                   |                                                             |  |                                    |  |                                                                                                                                                          |                |                                    |  |                                                                     |  | Years                                        |  |
| (c)                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |         |                   |                                                             |  |                                    |  |                                                                                                                                                          |                |                                    |  |                                                                     |  |                                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                       |  |         |                   |                                                             |  |                                    |  |                                                                                                                                                          |                |                                    |  |                                                                     |  |                                              |  |
| None                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |         |                   |                                                             |  |                                    |  |                                                                                                                                                          |                |                                    |  |                                                                     |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |  |         |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |                                    |  |                                                                                                                                                          |                |                                    |  | 20. AUTOPSY?                                                        |  |                                              |  |
| None                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |         |                   |                                                             |  |                                    |  |                                                                                                                                                          |                |                                    |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                              |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                      |  |         |                   | 21b. TIME OF INJURY                                         |  |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |                |                                    |  |                                                                     |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |         |                   | HOUR A.M. MONTH DAY YEAR                                    |  |                                    |  |                                                                                                                                                          |                |                                    |  |                                                                     |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |         |                   | P.M. 19                                                     |  |                                    |  | None                                                                                                                                                     |                |                                    |  |                                                                     |  |                                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                          |  |         |                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |                                    |  | 21f. LOCATION                                                                                                                                            |                |                                    |  |                                                                     |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |         |                   |                                                             |  |                                    |  | STREET CITY OR TOWN COUNTY STATE                                                                                                                         |                |                                    |  |                                                                     |  |                                              |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |         |                   |                                                             |  |                                    |  |                                                                                                                                                          |                |                                    |  |                                                                     |  |                                              |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                         |  |         |                   | TITLE (SPECIFY)                                             |  |                                    |  | DATE SIGNED                                                                                                                                              |                |                                    |  |                                                                     |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |         |                   | Deputy                                                      |  |                                    |  | 10/11/83                                                                                                                                                 |                |                                    |  |                                                                     |  |                                              |  |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                          |  |         |                   | ADDRESS                                                     |  |                                    |  |                                                                                                                                                          |                |                                    |  |                                                                     |  |                                              |  |
| John S. Rogers, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                     |  |         |                   | 1919 Seminary Road                                          |  |                                    |  |                                                                                                                                                          |                |                                    |  |                                                                     |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |         |                   | Silver Spring, Montgomery, Md.                              |  |                                    |  |                                                                                                                                                          |                |                                    |  |                                                                     |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                |  |         |                   | 23b. DATE                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY |  |                                                                                                                                                          |                | 23d. LOCATION                      |  |                                                                     |  |                                              |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |         |                   | 10/13/83                                                    |  | Wander's Rest Cem.                 |  |                                                                                                                                                          |                | Milwaukee, WI                      |  |                                                                     |  |                                              |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                     |  |         |                   | 25a. DATE REC'D. BY REGISTRAR                               |  |                                    |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                               |                |                                    |  |                                                                     |  |                                              |  |
| NAME ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                             |  |         |                   | OCT 14 1983                                                 |  |                                    |  |                                                                                                                                                          |                |                                    |  |                                                                     |  |                                              |  |
| Joseph Gawler's Sons, Inc.                                                                                                                                                                                                                                                                                                                                                                                                               |  |         |                   |                                                             |  |                                    |  |                                                                                                                                                          |                |                                    |  |                                                                     |  |                                              |  |
| 5130 Wisc. Ave. N.W. Wash., D. C. 20016                                                                                                                                                                                                                                                                                                                                                                                                  |  |         |                   |                                                             |  |                                    |  |                                                                                                                                                          |                |                                    |  |                                                                     |  |                                              |  |



CONFIDENTIAL

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

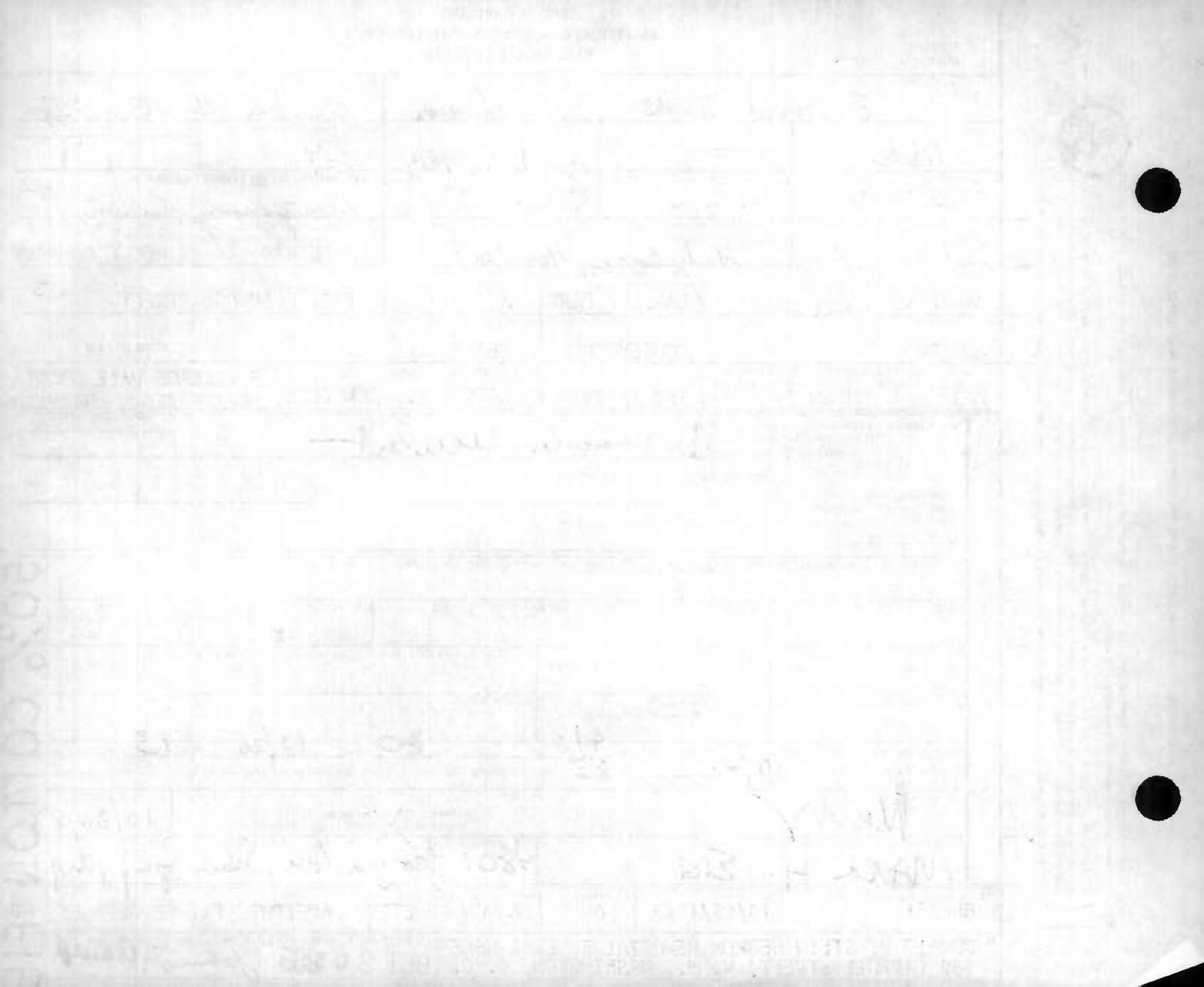
|                                                                                                                                                                                                                                                |  |                                                                                                           |  |                                                                               |  |                                                                     |  |                                                                                |  |                                                                |  |                                                 |  |                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|-------------------------------------------------|--|----------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                   |  |                                                                                                           |  |                                                                               |  |                                                                     |  |                                                                                |  |                                                                |  |                                                 |  |                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                            |  |                                                                                                           |  | 2a. DATE OF DEATH                                                             |  | MONTH                                                               |  | DAY                                                                            |  | YEAR                                                           |  | 2b. HOUR                                        |  |                            |  |
| Bernard JONAS Schoenbrun                                                                                                                                                                                                                       |  |                                                                                                           |  | October 20 1983                                                               |  |                                                                     |  |                                                                                |  |                                                                |  | 3:35 PM                                         |  |                            |  |
| 3. SEX                                                                                                                                                                                                                                         |  | 4. RACE                                                                                                   |  | 5. DATE OF BIRTH                                                              |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. UNDER 1 YEAR                                                                |  | 8. UNDER 2 HRS                                                 |  |                                                 |  |                            |  |
| Male                                                                                                                                                                                                                                           |  | WHITE                                                                                                     |  | April 9, 1914                                                                 |  | 69                                                                  |  | MONTHS                                                                         |  | DAYS                                                           |  | HOURS MIN.                                      |  |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                                                                |  |                                                                |  |                                                 |  |                            |  |
| PENNSYLVANIA                                                                                                                                                                                                                                   |  | U. S. A.                                                                                                  |  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | Montgomery County, MD                                               |  |                                                                                |  |                                                                |  |                                                 |  |                            |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)              |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                                                                |  |                                                                |  |                                                 |  |                            |  |
| Silver Spring                                                                                                                                                                                                                                  |  | Holy Cross Hospital                                                                                       |  | SALESMAN                                                                      |  | HECHT COMPANY                                                       |  |                                                                                |  |                                                                |  |                                                 |  |                            |  |
| 13a. STATE                                                                                                                                                                                                                                     |  | 13b. CITY OR TOWN                                                                                         |  | 13c. INSIDE CITY LIMITS?                                                      |  | 13d. STREET ADDRESS                                                 |  |                                                                                |  |                                                                |  |                                                 |  |                            |  |
| MARYLAND                                                                                                                                                                                                                                       |  | GEORGE'S                                                                                                  |  | V LANGLEY PARK                                                                |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1521 QUINWOOD STREET                                                           |  |                                                                |  |                                                 |  |                            |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                              |  |                                                                                                           |  | 15. MOTHER'S MAIDEN NAME                                                      |  |                                                                     |  |                                                                                |  |                                                                |  |                                                 |  |                            |  |
| ADOLPH                                                                                                                                                                                                                                         |  |                                                                                                           |  | PEARL                                                                         |  |                                                                     |  | FIERMAN                                                                        |  |                                                                |  |                                                 |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                           |  |                                                                                                           |  | 16b. SOCIAL SECURITY NO.                                                      |  |                                                                     |  | 17. INFORMANT                                                                  |  |                                                                |  |                                                 |  |                            |  |
| YES                                                                                                                                                                                                                                            |  |                                                                                                           |  | WW II                                                                         |  |                                                                     |  | 189-05-3558                                                                    |  |                                                                |  |                                                 |  |                            |  |
|                                                                                                                                                                                                                                                |  |                                                                                                           |  | MARCIA S. BERNSTEIN, REISTERSTOWN, MARYLAND                                   |  |                                                                     |  |                                                                                |  |                                                                |  |                                                 |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c).)                                                                                                                                                                      |  |                                                                                                           |  |                                                                               |  |                                                                     |  |                                                                                |  |                                                                |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |                            |  |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                   |  |                                                                                                           |  |                                                                               |  |                                                                     |  |                                                                                |  |                                                                |  |                                                 |  |                            |  |
| IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u>                                                                                                                                                                                            |  |                                                                                                           |  |                                                                               |  |                                                                     |  |                                                                                |  |                                                                |  |                                                 |  |                            |  |
| 4360                                                                                                                                                                                                                                           |  |                                                                                                           |  |                                                                               |  |                                                                     |  |                                                                                |  |                                                                |  |                                                 |  |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                 |  |                                                                                                           |  |                                                                               |  |                                                                     |  |                                                                                |  |                                                                |  |                                                 |  |                            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                 |  |                                                                                                           |  |                                                                               |  |                                                                     |  |                                                                                |  |                                                                |  |                                                 |  |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                 |  |                                                                                                           |  |                                                                               |  |                                                                     |  |                                                                                |  |                                                                |  |                                                 |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                               |  |                                                                                                           |  |                                                                               |  |                                                                     |  |                                                                                |  |                                                                |  |                                                 |  |                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                         |  |                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  |                                                                     |  | 20a. AUTOPSY?                                                                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                                                 |  |                            |  |
|                                                                                                                                                                                                                                                |  |                                                                                                           |  |                                                                               |  |                                                                     |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                                                 |  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                          |  |                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                               |  |                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |  |                                                                |  |                                                 |  |                            |  |
|                                                                                                                                                                                                                                                |  |                                                                                                           |  | P.M. 19                                                                       |  |                                                                     |  |                                                                                |  |                                                                |  |                                                 |  |                            |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                           |  |                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |  |                                                                     |  | 21f. LOCATION                                                                  |  |                                                                |  |                                                 |  |                            |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                      |  |                                                                                                           |  |                                                                               |  |                                                                     |  | STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                |  |                                                 |  |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/10</u> 19 <u>80</u> to <u>10/20</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>10/20</u> above (I) (we) (did) (did not) view the body after death. |  |                                                                                                           |  |                                                                               |  |                                                                     |  |                                                                                |  |                                                                |  |                                                 |  |                            |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                 |  |                                                                                                           |  |                                                                               |  |                                                                     |  |                                                                                |  |                                                                |  | DEGREE                                          |  |                            |  |
| <u>Mark H. Eig</u>                                                                                                                                                                                                                             |  |                                                                                                           |  |                                                                               |  |                                                                     |  |                                                                                |  |                                                                |  |                                                 |  |                            |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                          |  |                                                                                                           |  |                                                                               |  |                                                                     |  |                                                                                |  |                                                                |  | 22d. ADDRESS                                    |  |                            |  |
| MARK H. EIG                                                                                                                                                                                                                                    |  |                                                                                                           |  |                                                                               |  |                                                                     |  |                                                                                |  |                                                                |  | 9801 Georgia Ave, Silver Spring, Md             |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL                                                                                                                                                                                                                |  |                                                                                                           |  | 23b. DATE                                                                     |  |                                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY                                             |  |                                                                |  | 23d. LOCATION                                   |  |                            |  |
| BURIAL                                                                                                                                                                                                                                         |  |                                                                                                           |  | 10/23/1983                                                                    |  |                                                                     |  | MOUNT LEBANON CEMETERY                                                         |  |                                                                |  | ADELPHI, PRINCE GEORGES, MD.                    |  |                            |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                           |  |                                                                                                           |  |                                                                               |  |                                                                     |  |                                                                                |  |                                                                |  | 25a. DATE REC'D. BY REGISTRAR                   |  | 25b. REGISTRAR'S SIGNATURE |  |
| DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME                                                                                                                                                                                                   |  |                                                                                                           |  |                                                                               |  |                                                                     |  |                                                                                |  |                                                                |  | OCT 26 1983                                     |  | <u>John J. Lohr</u>        |  |
| 232 CARROLL STREET, N. W., WASHINGTON, D. C.                                                                                                                                                                                                   |  |                                                                                                           |  |                                                                               |  |                                                                     |  |                                                                                |  |                                                                |  |                                                 |  |                            |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For a medical examiner's certificate, see separate form.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                        |                                                                                                                                                             |                                                                                      |                                                                                                 | REG. NO.                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>REGIS FRANKLIN SCHROLL</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 19, 1983</b>                       |                                                                                                 | 2b. HOUR<br><b>11:30 P.M.</b>                                                                       |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE<br><b>WHITE</b>                                                                                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 21, 1920</b>                                                                                               |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.                                               |                                                                                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                            |                                                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Clinical Center, NIH, Bethesda, Md</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Assembler</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Robertshaw Corp.</b>                                        |  |
| 13a. STATE<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                        | 13b. COUNTY<br><b>Westmoreland</b>                                                                                                                          | 13c. CITY OR TOWN<br><b>MT. Pleasant</b>                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Schroll</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Rimlinger</b>                                                                                  |                                                                                      |                                                                                                 |                                                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                        | 16b. SOCIAL SECURITY NO.<br><b>WW 11 160-12-8632</b>                                                                                                        |                                                                                      | 17. INFORMANT<br>ADDRESS<br><b>Suzanne Schroll (wife), Mt Pleasant, PA</b>                      |                                                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RENAL FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>RETROPERITONEAL SARCOMA</b>                                                                                                                                 |                                                                                                                                                        |                                                                                                                                                             |                                                                                      |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 HRS</b><br><b>5-7 DAYS</b><br><b>2 MONTHS</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>RESPIRATORY INSUFFICIENCY HEPATIC FAILURE</b>                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                        |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                                                                     |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                        |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                  |                                                                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                     |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 18, 1983</b> to <b>October 19, 1983</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>October 19, 1983</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. |                                                                                                                                                        |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                     |  |
| 22b. SIGNATURE<br><b>Thomas D. McClain MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                        | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                                      | 22c. DATE SIGNED<br><b>10/20/83</b>                                                             |                                                                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>THOMAS D. McCLAIN MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                        | 22e. ADDRESS<br><b>National Institutes of Health<br/>Clinical Center, Bethesda, MD., 20205</b>                                                              |                                                                                      |                                                                                                 |                                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                        | 23b. DATE<br><b>October 24, 1983</b>                                                                                                                        |                                                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Pius X</b>                                         |                                                                                                     |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Westmoreland County, PA.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                        |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                        |                                                                                                                                                             |                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 25 1983</b>                                             |                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                        |                                                                                                                                                             |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                             |                                                                                                     |  |

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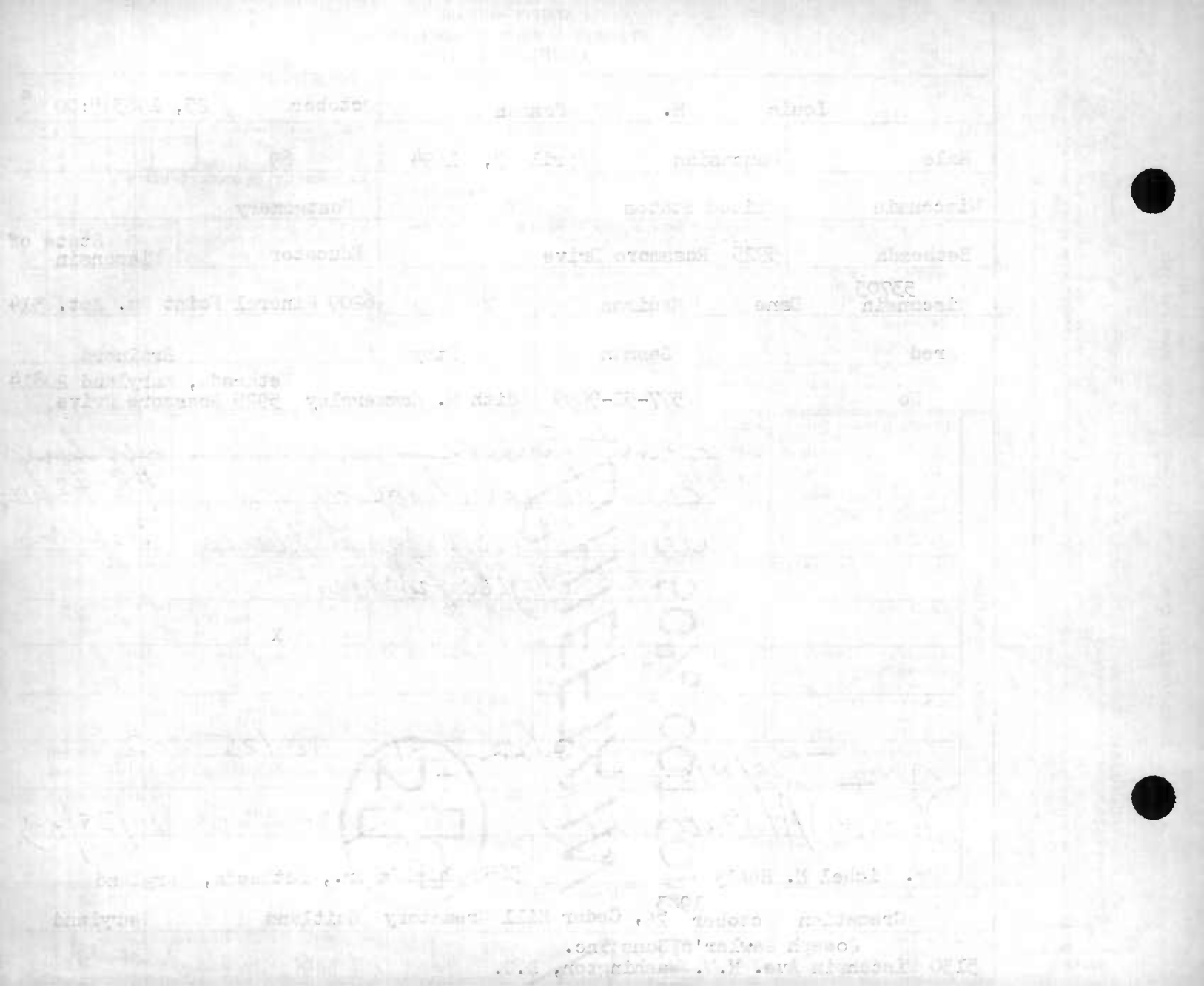


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                  |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                     |                                                                                                                            |  |                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|-------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                  |  |                                                                                                                                                             | REG. NO.                                                                                                                                             |                                                                                                 |                                                     |                                                                                                                            |  |                               |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Louis M. Sasman                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                  |  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 25, 1983                                                                                              |                                                                                                 |                                                     |                                                                                                                            |  | 2b. HOUR<br>5:00<br>a.m.      |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br>Caucasian                                                                                                             |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 3, 1894                                                                                                         |                                                                                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>89 YRS.                                                      |                                                     | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                             |  | IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Wisconsin                                                                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States                                                                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                                          |                                                     |                                                                                                                            |  |                               |
| 10. CITY OR TOWN OF DEATH<br>Bethesda                                                                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>5925 Rossmore Drive |  |                                                                                                                                                             |                                                                                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Educator                    |                                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br>State of Wisconsin                                                                    |  |                               |
| 13a. STATE<br>Wisconsin                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY<br>Dane                                                                                                              |  | 13c. CITY OR TOWN<br>Madison                                                                                                                                |                                                                                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                     | 13e. STREET ADDRESS<br>6209 Mineral Point Rd. Apt. 514                                                                     |  |                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Fred Sasman                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                  |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ethyl Brainerd                                                                                      |                                                                                                 |                                                     |                                                                                                                            |  |                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>577-52-9099                                                           |  | 17. INFORMANT<br>ADDRESS<br>Bethesda, Maryland 20814<br>Edith M. Hammersley 5925 Rossmore Drive                                                             |                                                                                                                                                      |                                                                                                 |                                                     |                                                                                                                            |  |                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Heart Failure</u><br>2050<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Sal. hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Acute Myelogenous Leukemia</u><br>and <u>thrombocytopenia</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>see below</u><br><u>#8-72 hours</u><br><u>3 years</u> |  |                                                                                                                                  |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                     |                                                                                                                            |  |                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I<br><u>and thrombocytopenia</u>                                                                                                                                                                                                                                                                                     |  |                                                                                                                                  |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                     |                                                                                                                            |  |                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |  |                                                                                                                                                             |                                                                                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                                                                                                      |                                                                                                 |                                                     |                                                                                                                            |  |                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                           |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                                                                      |                                                                                                 |                                                     |                                                                                                                            |  |                               |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>12/15</u> 19 <u>81</u> , to <u>10/25</u> 19 <u>83</u> , that (I) <del>was</del> last saw the deceased alive on <u>10/21/83</u> 19 <u>83</u> , and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> did not view the body after death.                                                             |  |                                                                                                                                  |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                     |                                                                                                                            |  |                               |
| 22b. SIGNATURE<br><u>Michel M. Healy MD</u>                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                  |  |                                                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br>10/25/83                        |                                                                                                                            |  |                               |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Michel M. Healy                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                  |  |                                                                                                                                                             | 23b. ADDRESS<br>5652 Shields Dr., Bethesda, Maryland                                                                                                 |                                                                                                 |                                                     |                                                                                                                            |  |                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br>1983<br>October 26                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Crematory                                                                                                  |                                                                                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland Maryland                                 |                                                     |                                                                                                                            |  |                               |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph Gawler's Sons Inc.<br>5130 Wisconsin Ave. N.W. Washington, D.C.                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                  |  |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>OCT 27 1983                                                                                                         |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Gawler</u> |                                                                                                                            |  |                               |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                     |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                        |  |                                                                                      |  | REG. NO.                                                                                                                              |  |                                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DONNIE LEE SEABOCH</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                     |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 16 1983</b>                                                                                               |  |                                                                                      |  | 2b. HOUR<br><b>12:45<sup>PM</sup></b>                                                                                                 |  |                                                    |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>CAUCASIAN</b>                                                                                                         |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JUNE 17 1946</b>                                                                                                   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>37</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                        |  | IF UNDER 74 HRS.<br>HOURS MIN.                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>TENNESSEE</b>                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>                                                                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                        |  |                                                                                                                                       |  |                                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN HOSPITAL, CITY, GIVE STREET ADDRESS)<br><b>NAVAL HOSPITAL</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cook</b>      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Jail</b>                                                                                      |  |                                                    |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                     |  |                                                                                                                                     |  | 13b. COUNTY<br><b>PRINCE GEORGES</b>                                                                                                                        |  | 13c. CITY OR TOWN<br><b>HYATTSVILLE</b>                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  | 13e. STREET ADDRESS<br><b>4806 49TH AVE. 20781</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Chall LEROY SEABOCH</b>                                                                                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>NEIL DARE GRINDSTAFF</b>                                                        |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                                       |  |                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br><b>1963-1978</b>                                                                                        |  | 17. INFORMANT<br><b>MARY ELIZABETH SEABOCH</b>                                                                                                              |  | ADDRESS<br><b>4806 49TH AVE HYATTSVILLE MD 20781</b>                                 |  |                                                                                                                                       |  |                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BURKETT'S LYMPHOMA</b><br><b>2002</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>BURKITT'S</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>BURKITT'S</b> |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                                       |  |                                                    |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                          |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                                       |  |                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                    |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                      |  |                                                                                                                                       |  |                                                    |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                              |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                      |  |                                                                                                                                       |  |                                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 16 1983</b> , to <b>OCTOBER 16 1983</b> , that (I) (we) lost saw the deceased alive on <b>OCTOBER 16 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                                       |  |                                                    |  |
| 22b. SIGNATURE<br><b>R.L. Sollock</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                     |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |                                                                                      |  | 22c. DATE SIGNED<br><b>17 Oct 83</b>                                                                                                  |  |                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R.L. SOLLOCK LCDR MC USN</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                     |  | 22e. ADDRESS<br><b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND NATIONAL CAPITAL REGION BETHESDA</b>                                                               |  |                                                                                      |  |                                                                                                                                       |  |                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br><b>Oct. 20, 1983</b>                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Vet. Cemetery</b>                                                                                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cheltenham P.G. Maryland</b>        |  | 23e. DATE REC'D. BY REGISTRAR<br><b>19 OCT 1983</b>                                                                                   |  |                                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                     |  | 25a. DATE REC'D. BY REGISTRAR<br><b>19 OCT 1983</b>                                                                                                         |  |                                                                                      |  |                                                                                                                                       |  |                                                    |  |

BP

W. Archibald & Sons, Ltd., 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                     |  | REG. NO.                                                                                                                                                 |  |                                                                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                     |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                         |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>WALTER E. SEYMOUR</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                     |  | OCTOBER 4, 1983                                                                                                                                          |  |                                                                                                                         |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br><b>WHITE</b>                                                                                                             |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>JUNE 12, 1889</b>                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><b>94</b>                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>OHIO</b>                                                                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                       |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>WHEATON</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MANOR CARE WHEATON</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>VETERINARIAN</b>                                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>TAIL WAGGERS CLINIC</b>                                                         |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                     |  | 13b. COUNTY<br><b>MONTGOMERY</b>                                                                                                                         |  | 13c. CITY OR TOWN<br><b>SILVER SPRING</b>                                                                               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>EDWARD SEYMOUR</b>                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>S OSA FRY</b>                                                                                           |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>WW I 578-06-6130</b>                                                     |  | 17. INFORMANT ADDRESS<br><b>SANDRA SHEPPARD, DAUGHTER, SIL. SPG., MD. 114 FLEETWOOD TERR.</b>                                                            |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Atherosclerotic Cardiovascular Disease</b><br><b>4292</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> |  |                                                                                                                                     |  |                                                                                                                                                          |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: _____                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                     |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION<br><b>✓</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>✓</b>                                                                        |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>✓</b>                                                               |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>✓</b>                                                     |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>✓</b>                                                                                               |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 7, 1983</b> to <b>OCT 4, 1983</b> , that (I) (we) lost saw the deceased alive on <b>SEPTEMBER 1, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                     |  |                                                                                                                                     |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 22b. SIGNATURE <b>Raymond Bass</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>           |  | 22c. DATE SIGNED <b>10-5-83</b>                                                                                                                          |  |                                                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAYMOND BASS</b>                                                                                                                                                                                                                                                                                                                                                                                        |  | 22e. ADDRESS<br><b>3929 Ferrara Dr Wheaton 20906 Md.</b>                                                                            |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br><b>10/5/83</b>                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL CREMATORY</b>                                                                                        |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>SUITLAND PG. MD.</b>                                                      |  |
| 24. FUNERAL DIRECTOR NAME<br><b>RICHARD RAPP, INC</b>                                                                                                                                                                                                                                                                                                                                                                                               |  | ADDRESS<br><b>1120 CONN. AVE. N.W. #940, WASH. D.C. 20036</b>                                                                       |  | 25a. DATE REC'D. BY REGISTRAR & REGISTRAR'S SIGNATURE<br><b>OCT 10 1983</b>                                                                              |  |                                                                                                                         |  |

BP

DATE: 10/10/50

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: 10/10/50

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: 10/10/50

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: 10/10/50

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMM - 16 50M 4/82  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                            |  |                                                                                                                                       |  |                                                                                                                                                             |                                                                   |                                                                                      |                                                                            |                                                                                                                            |                                                                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                       |  |                                                                                                                                                             | REG. NO.                                                          |                                                                                      |                                                                            |                                                                                                                            |                                                                                                 |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>William H. Shaw</i>                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>10 26 83</i>               |                                                                                      |                                                                            | 2b. HOUR<br><i>2:20</i> M                                                                                                  |                                                                                                 |  |
| 3. SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><i>White</i>                                                                                                               |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>3-21-1895</i>                                                                                                         |                                                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>88</i> YRS.                                    |                                                                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |                                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Virginia</i>                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Mont.</i> MD.                             |                                                                            |                                                                                                                            |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><i>Takoma Park</i>                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Washington Adventist</i> |  |                                                                                                                                                             |                                                                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Ret. Baker</i>   |                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>-</i>                                                                              |                                                                                                 |  |
| 13a. STATE<br><i>Md.</i>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                       |  |                                                                                                                                                             | 13b. COUNTY<br><i>Pr. Geo.</i>                                    |                                                                                      | 13c. CITY OR TOWN<br><i>Hy.</i>                                            |                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>William Shaw</i>                                                                                                                                                                                                                                                                      |  |                                                                                                                                       |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Ida Mae King</i> |                                                                                      |                                                                            |                                                                                                                            |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>Yes WWI</i>                                                                                                                                                                                                                 |  |                                                                                                                                       |  |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br><i>578-01-5929A</i>                   |                                                                                      | 17. INFORMANT ADDRESS<br><i>Eugene H. Shaw 8767-Contee Rd. Laurel, Md.</i> |                                                                                                                            |                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><i>4860 IMMEDIATE CAUSE (a) Pneumonia</i>                                                                                                                                                                          |  |                                                                                                                                       |  |                                                                                                                                                             |                                                                   |                                                                                      |                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>17 days</i>                                                             |                                                                                                 |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)                                                                                                                                                                                                                                                                                              |  |                                                                                                                                       |  |                                                                                                                                                             |                                                                   |                                                                                      |                                                                            |                                                                                                                            |                                                                                                 |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                                              |  |                                                                                                                                       |  |                                                                                                                                                             |                                                                   |                                                                                      |                                                                            |                                                                                                                            |                                                                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><i>Generalized Atherosclerosis Stroke Chronic Obstructive Lung Disease</i>                                                                                                                  |  |                                                                                                                                       |  |                                                                                                                                                             |                                                                   |                                                                                      |                                                                            |                                                                                                                            |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |  |                                                                                                                                                             |                                                                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                                                                              |                                                                   |                                                                                      |                                                                            |                                                                                                                            |                                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                   |                                                                                      |                                                                            |                                                                                                                            |                                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10-25-83</i> to <i>10/26-83</i> , that (I) (we) last saw the deceased alive on <i>10-25-83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                       |  |                                                                                                                                                             |                                                                   |                                                                                      |                                                                            |                                                                                                                            |                                                                                                 |  |
| 22b. SIGNATURE<br><i>Alan R. Gair MD</i>                                                                                                                                                                                                                                                                                        |  |                                                                                                                                       |  | DEGREE                                                                                                                                                      |                                                                   |                                                                                      |                                                                            | 22c. DATE SIGNED<br><i>10/26/83</i>                                                                                        |                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Alan R. Gair MD</i>                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  | 22e. ADDRESS<br><i>11700 Old Columbia Pike Silver Spring, Md.</i>                                                                                           |                                                                   |                                                                                      |                                                                            |                                                                                                                            |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><i>10-28-83</i>                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill Cem.</i>                                                                                                |                                                                   |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Suitland Pr. Geo. Md.</i> |                                                                                                                            |                                                                                                 |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Nalley's F.H. Inc.</i>                                                                                                                                                                                                                                                                          |  |                                                                                                                                       |  | ADDRESS<br><i>Mt. Rainier, Md.</i>                                                                                                                          |                                                                   | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 31 1983</i>                                  |                                                                            | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Gair</i>                                                                          |                                                                                                 |  |

MEDICAL CERTIFICATE

• • •

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                   |                                                       |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Dr. William C.C. SHEN</i>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>10 8 83</i> |                                                                                                                                                             |  | 2b. HOUR<br><i>8:31 P.M.</i>                                                                    |  |                                                                                                                            |  |
| 3. SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><i>Oriental</i>                                                                                                                        |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>April 29 1920</i>                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>63</i> YRS.                                               |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>China</i>                                                                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                                     |                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Prince George MONT. Co. MD.</i>                      |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><i>Takoma Park</i>                                                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Washington Adventist Hospital</i> |                                                       |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Meteorologist</i>        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Federal Gov't.</i>                                                                 |  |
| 13a. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                                                                                |  | 13b. COUNTY<br><i>Prince Geo.</i>                                                                                                                 |                                                       | 13c. CITY OR TOWN<br><i>Ft. Washington</i>                                                                                                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>13207 L'Enfant Drive</i>                                                                         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Jien Shi Shen</i>                                                                                                                                                                                                                                                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Unknown Hsu</i>                                                                               |                                                       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR NO OR UNKNOWN)<br><i>No</i>                                                                         |  | 16b. SOCIAL SECURITY NO.<br><i>064 32 5395</i>                                                  |  | 17. INFORMANT<br><i>Karen Shen</i>                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction Massive</i><br><i>4100</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>14 31 hr.</i>                                                                                  |                                                       | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                      |  |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                  |                                                       |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>                                                                                 |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                            |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (1) <del>this hospital</del> attended the deceased from <i>10/8</i> , 19 <i>83</i> , to <i>10/8</i> , 19 <i>83</i> , that (1) <del>was</del> <i>was</i> <del>the</del> <i>was</i> <del>deceased</del> <i>deceased</i> <del>alive</del> <i>alive</i> <del>on</del> <i>on</i> <del>above</del> <i>above</i> , (2) <del>was</del> <i>was</i> <del>did</del> <i>did</i> <del>not</del> <i>not</i> view the body after death. |  |                                                                                                                                                   |                                                       |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><i>Bernadette C.F. Soong MD</i>                                                                                                                                                                                                                                                                                                                                                                                            |  | DEGREE<br><i>MD</i>                                                                                                                               |                                                       | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |                                                                                                 |  | 22c. DATE SIGNED<br><i>10/8/83</i>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>BERNADETTE C.F. SOONG, MD.</i>                                                                                                                                                                                                                                                                                                                                                                   |  | 22e. ADDRESS<br><i>1106 Spring Street Silver Spring Md 20910</i>                                                                                  |                                                       |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Cremation</i>                                                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br><i>10/12/83</i>                                                                                                                      |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill Crematory</i>                                                                                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Suitland P. G. Maryland</i>                    |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>George P. Kalas Funeral Home</i>                                                                                                                                                                                                                                                                                                                                                                          |  | ADDRESS<br><i>6160 Oxon Hill Rd. Oxon Hill, Md.</i>                                                                                               |                                                       | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 14 1983</i>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Gault</i>                                              |  |                                                                                                                            |  |

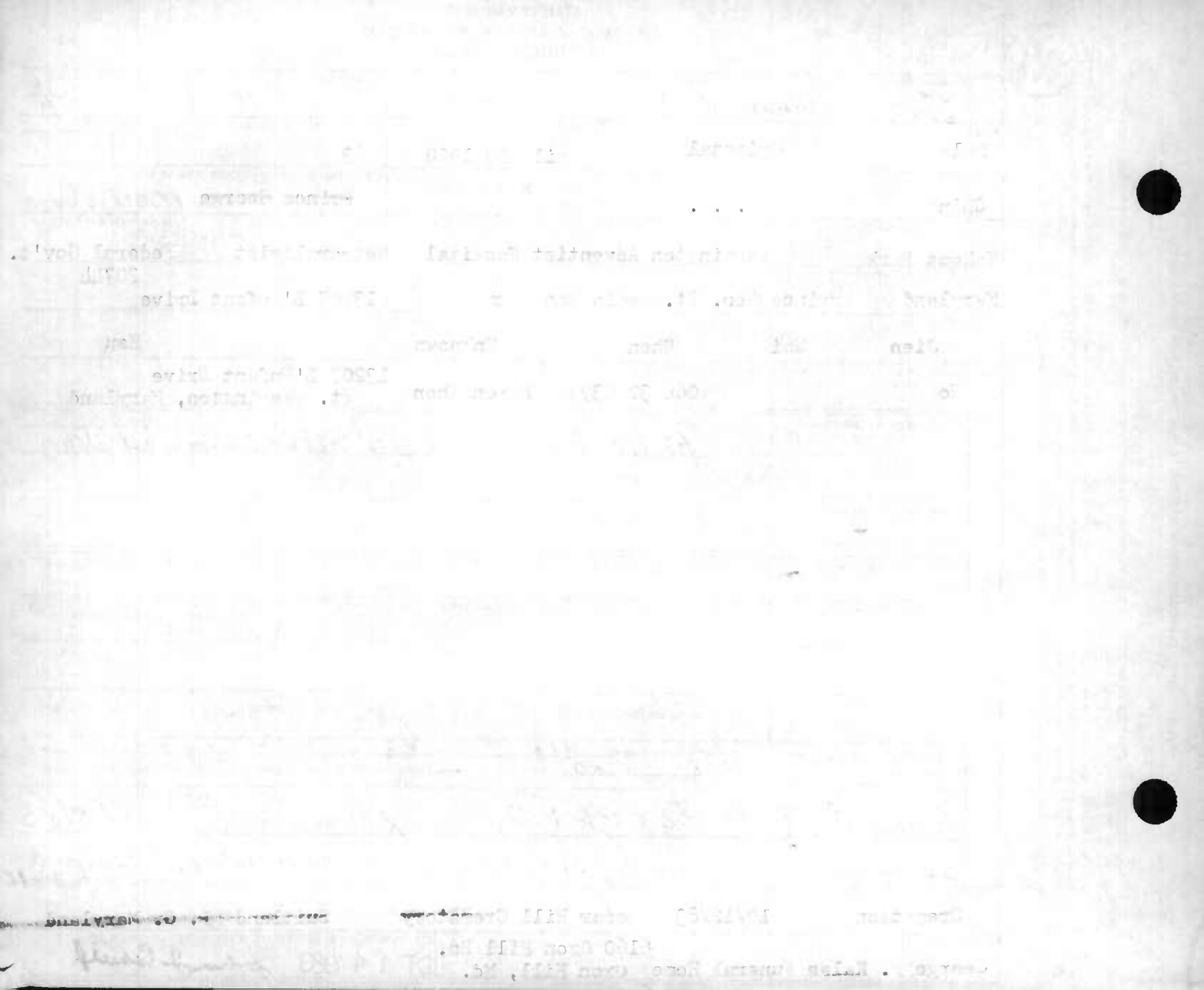
BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                       |                                            |                                                                                                                                         |                                                                                      |                                                                                    | REG. NO.                                                      |                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|---------------------------------------------------------------|------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Aubrey</b> <b>E.</b> <b>Shoemaker</b>                                                                                                                                                                                                                                                                                                                               |                                            |                                                                                                                                         | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10 19 83</b>                                  |                                                                                    | 2b. HOUR<br><b>10<sup>15</sup> PM</b>                         |                                                      |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                      | 4. RACE<br><b>White</b>                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 09 1915</b>                                                                                 |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67 yrs</b>                                   |                                                               | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.            |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>District Columbia USA</b>                                                                                                                                                                                                                                                                                                                               | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED<br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>      |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                      |                                                               |                                                      |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                                                                                                                                                                                                                                                                                                                                                          |                                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Plumber</b> |                                                               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Plumbing</b> |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                    |                                            |                                                                                                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                    |                                                               |                                                      |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                   | 13b. COUNTY<br><b>Montgomery</b>           | 13c. CITY OR TOWN<br><b>Silver Spring</b>                                                                                               | 13e. STREET ADDRESS<br><b>2601 Bel Pre Road</b>                                      |                                                                                    |                                                               |                                                      |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William E Shoemaker</b>                                                                                                                                                                                                                                                                                                                                       |                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>May I. Passeno</b>                                                                  |                                                                                      |                                                                                    |                                                               |                                                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                         |                                            | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII</b>                                                                  |                                                                                      | 17. INFORMANT<br>ADDRESS<br><b>Station, Va.</b>                                    |                                                               |                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                            |                                            | <b>579-09-7098</b>                                                                                                                      |                                                                                      | <b>Mildred S Elliott. 11605 Choir Ln., Fairfax</b>                                 |                                                               |                                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF,<br>(b) <b>Chronic Obstructive Pulmonary Dis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>4 yrs</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                                            |                                                                                                                                         |                                                                                      |                                                                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b> |                                                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16.                                                                                                                                                                                                                                                                       |                                            |                                                                                                                                         |                                                                                      |                                                                                    |                                                               |                                                      |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                     |                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                        |                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |                                                               |                                                      |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                 |                                            |                                                                                                                                         |                                                                                      |                                                                                    |                                                               |                                                      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                   |                                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                              |                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)     |                                                               |                                                      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                               |                                            | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |                                                               |                                                      |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/19</b> 19 <b>83</b> to <b>10/19</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>10/19</b> 19 <b>83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                |                                            |                                                                                                                                         |                                                                                      |                                                                                    |                                                               |                                                      |
| 22b. SIGNATURE<br><b>R. I. Benackry</b>                                                                                                                                                                                                                                                                                                                                                                    |                                            | DEGREE<br><b>MD</b>                                                                                                                     |                                                                                      | 22c. DATE SIGNED<br><b>10/20/83</b>                                                |                                                               |                                                      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. I. Benackry</b>                                                                                                                                                                                                                                                                                                                                             |                                            | 22e. ADDRESS<br><b>4115 Colie Dr. Wheaton, MD</b>                                                                                       |                                                                                      |                                                                                    |                                                               |                                                      |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                              |                                            | 23b. DATE<br><b>10/22/1983</b>                                                                                                          |                                                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>                   |                                                               |                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                            |                                            |                                                                                                                                         |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland, Maryland</b>            |                                                               |                                                      |
| 24. FUNERAL DIRECTOR<br><b>Joseph Gawler's Son's Inc.</b>                                                                                                                                                                                                                                                                                                                                                  |                                            |                                                                                                                                         | 25a. DATE REC'D. BY REGISTRAR                                                        |                                                                                    |                                                               |                                                      |
| <b>5130 Wisc. Ave., N.W. Wash., D.C.</b>                                                                                                                                                                                                                                                                                                                                                                   |                                            |                                                                                                                                         | 25b. REGISTRAR'S SIGNATURE<br><b>OCT 25 1983 Inc. &amp; Co.</b>                      |                                                                                    |                                                               |                                                      |



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                              |  |                                                                                                                                                    |                                                     |                                                                                                                                                             |  |                                                                                                 |  |                                                              |  |
|------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Theodore - Shrader</i>                                                                |  |                                                                                                                                                    | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>10 23 83</i> |                                                                                                                                                             |  | 2b. HOUR<br><i>6:05A.M.</i>                                                                     |  |                                                              |  |
| 3. SEX<br><i>Male</i>                                                                                                        |  | 4. RACE<br><i>White</i>                                                                                                                            |                                                     | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>June 9, 1913</i>                                                                                                      |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>70</i> YRS.                                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>W. Va.</i>                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                                      |                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery Co., MD.</i>                              |  |                                                              |  |
| 10. CITY OR TOWN OF DEATH<br><i>Rockville</i>                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Shady Grove Adventist Hospital</i> |                                                     |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Custodian</i>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>School</i>           |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><i>Maryland</i> |  | 13b. COUNTY<br><i>Montgomery</i>                                                                                                                   |                                                     | 13c. CITY OR TOWN<br><i>Gaithersburg</i>                                                                                                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>858 Quince Orchard Blvd. 20878</i> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>James Shrader</i>                                                               |  |                                                                                                                                                    |                                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Lillie Riley</i>                                                                                        |  |                                                                                                 |  |                                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><i>No</i>                                           |  |                                                                                                                                                    |                                                     | 16b. SOCIAL SECURITY NO.<br><i>223-10-6356</i>                                                                                                              |  | 17. INFORMANT ADDRESS<br><i>Phyllis E. Shrader, Item 13</i>                                     |  |                                                              |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Cardiac arrest*

*4254*  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) *Congestive Cardiomyopathy*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
*immed*

*5 yrs*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

*Bilateral pleural effusion*

|                                                                                                                                                                                                                                                                                                                                                                |  |                                                                        |  |                                                                                |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                                                                                                            |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>10/17</i> , 19 <i>83</i> , to <i>10/23</i> , 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>10/22</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |                                                                        |  |                                                                                |  |                                                                                                                            |  |

|                                                                    |  |                                                                |  |                                                                                                                                               |  |                                     |  |
|--------------------------------------------------------------------|--|----------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------|--|
| 22b. SIGNATURE<br><i>Robert Millman MD</i>                         |  | DEGREE<br><i>MD</i>                                            |  | ATTENDING MEDICAL STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>10/23/83</i> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Robert Millman, MD</i> |  | 22e. ADDRESS<br><i>1512 Deer Park Dr Gaithersburg Md 20877</i> |  |                                                                                                                                               |  |                                     |  |

|                                                                        |  |                                   |  |                                                        |  |                                                                                |  |
|------------------------------------------------------------------------|--|-----------------------------------|--|--------------------------------------------------------|--|--------------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>          |  | 23b. DATE<br><i>Oct. 25, 1983</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Resthaven</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Frederick, Frederick, Md.</i> |  |
| 24. FUNERAL DIRECTOR<br><i>John L. Molesworth, P.A., Damascus, Md.</i> |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 26 1983</i>    |  |                                                                                |  |
|                                                                        |  |                                   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Carter</i>    |  |                                                                                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed in the county after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

Official  
Wash. D.C., 25, 1963  
John F. Kennedy, Jr.  
Washington, D.C.

Technical, Technical, etc.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                               |  |                                                                                                                                         |                                                        |                                                                                                                                                             |  |                                                                                             |  |
|---------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>(Sickler) John T. Sickler</b>                                       |  |                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 31 83</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>10:35 AM</b>                                                                 |  |
| 3. SEX<br><b>MALE</b>                                                                                         |  | 4. RACE<br><b>WHITE</b>                                                                                                                 |                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 11 10</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73 YRS</b>                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW JERSEY</b>                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                              |                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |                                                        |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PLUMBER BUSINESS</b> |  |
| 13a. STATE<br><b>MD.</b>                                                                                      |  | 13b. COUNTY<br><b>MONTGOMERY</b>                                                                                                        |                                                        | 13c. CITY OR TOWN<br><b>BURTENVILLE</b>                                                                                                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WALTER SCOTT SICKLER</b>                                         |  |                                                                                                                                         |                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNA B. TITUS</b>                                                                                       |  |                                                                                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b> |  |                                                                                                                                         |                                                        | 16b. SOCIAL SECURITY NO.<br><b>578-01-1381</b>                                                                                                              |  | 17. INFORMANT<br>ADDRESS<br><b>BETTY T. SICKLER, 4021 DUSTIN RD</b>                         |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Stroke**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
**2 days**

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Thrombocytopenia****1 month**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Acute Myelogenous Leukemia****1 month**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**Anemia, Neutropenia**

|                                                                                                                                                                                                                                                                                                                                  |  |                                                                        |  |                                                                                |  |                                                                                                                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION<br><b>10/31/83</b>                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/31/83</b> to <b>10/31/83</b> , that (II) (we) last saw the deceased alive on <b>10/31/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>Peter B. Sherer MD</b>                                                                                                                                                                                                                                                                                      |  |                                                                        |  | DEGREE<br><b>MD</b>                                                            |  | 22c. DATE SIGNED<br><b>10/31/83</b>                                                                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Peter B. Sherer MD</b>                                                                                                                                                                                                                                                               |  |                                                                        |  | 22e. ADDRESS<br><b>3947 Ferrara Dr. Wheaton, Md 20906</b>                      |  |                                                                                                                               |  |

|                                                                        |  |                                 |  |                                                                       |  |                                                                          |  |
|------------------------------------------------------------------------|--|---------------------------------|--|-----------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>          |  | 23b. DATE<br><b>Nov 3, 1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Marlboro Church Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brighton New Jersey</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Takoma Funeral Home 8800 Wilton</b> |  |                                 |  | ADDRESS<br><b>254 Canal St NW DC</b>                                  |  | 25. DATE REC'D BY REGISTRAR<br><b>NOV 02 1983</b>                        |  |
| 26. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                     |  |                                 |  |                                                                       |  |                                                                          |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                    |  |  |                                                                                                        |  |  |                                                                                                                                                          |  |  |                                                                     |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------|--|--|
| 1. FOR STATE REGISTRAR                                                                                                                             |  |  | 2a. DATE OF DEATH                                                                                      |  |  | MONTH DAY YEAR                                                                                                                                           |  |  | 2b. HOUR                                                            |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                   |  |  | FIRST MIDDLE LAST                                                                                      |  |  | 2b. DATE OF DEATH                                                                                                                                        |  |  | 2b. HOUR                                                            |  |  |
| JOE D Simmons                                                                                                                                      |  |  |                                                                                                        |  |  | OCT 20 1983                                                                                                                                              |  |  | 2130 M                                                              |  |  |
| 3. SEX                                                                                                                                             |  |  | 4. RACE                                                                                                |  |  | 5. DATE OF BIRTH                                                                                                                                         |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |  |
| Male                                                                                                                                               |  |  | Caucasian                                                                                              |  |  | Jan. 3, 1932                                                                                                                                             |  |  | 51 YRS.                                                             |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                          |  |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |
| West Virginia                                                                                                                                      |  |  | United States                                                                                          |  |  |                                                                                                                                                          |  |  | Montgomery MD                                                       |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                          |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |
| SILVER SPRING                                                                                                                                      |  |  | HOLY CROSS HOSPITAL                                                                                    |  |  | Equipment Installer                                                                                                                                      |  |  | Western Electric                                                    |  |  |
| 13a. STATE                                                                                                                                         |  |  | 13b. COUNTY                                                                                            |  |  | 13c. CITY OR TOWN                                                                                                                                        |  |  | 13d. INSIDE CITY LIMITS?                                            |  |  |
| MD                                                                                                                                                 |  |  | MONTGOMERY                                                                                             |  |  | ROCKVILLE                                                                                                                                                |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME                                                                                                                                  |  |  | 15. MOTHER'S MAIDEN NAME                                                                               |  |  | 13e. STREET ADDRESS                                                                                                                                      |  |  |                                                                     |  |  |
| FIRST MIDDLE LAST                                                                                                                                  |  |  | FIRST MIDDLE LAST                                                                                      |  |  | 20851                                                                                                                                                    |  |  |                                                                     |  |  |
| Roy F. Simmons                                                                                                                                     |  |  | Maude Dunkle                                                                                           |  |  | 13203 TWIN BROOK PKWY                                                                                                                                    |  |  |                                                                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                  |  |  | 16b. SOCIAL SECURITY NO.                                                                               |  |  | 17. INFORMANT                                                                                                                                            |  |  | ADDRESS                                                             |  |  |
| No                                                                                                                                                 |  |  | 579 40 6639                                                                                            |  |  | Mother                                                                                                                                                   |  |  | Same as item 13                                                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:                                              |  |  | IMMEDIATE CAUSE (a)                                                                                    |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                             |  |  |                                                                     |  |  |
| 4140                                                                                                                                               |  |  | Sudden cardiac death                                                                                   |  |  | 1 hour                                                                                                                                                   |  |  |                                                                     |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                     |  |  | (b)                                                                                                    |  |  |                                                                                                                                                          |  |  |                                                                     |  |  |
|                                                                                                                                                    |  |  | possible myocardial Ventricular                                                                        |  |  |                                                                                                                                                          |  |  |                                                                     |  |  |
|                                                                                                                                                    |  |  | (c)                                                                                                    |  |  |                                                                                                                                                          |  |  |                                                                     |  |  |
|                                                                                                                                                    |  |  | Distal aortic aneurysm                                                                                 |  |  |                                                                                                                                                          |  |  |                                                                     |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                   |  |  | Congestive Heart Failure                                                                               |  |  |                                                                                                                                                          |  |  |                                                                     |  |  |
| 19a. DATE OF OPERATION                                                                                                                             |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |  | 20a. AUTOPSY?                                                                                                                                            |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |
|                                                                                                                                                    |  |  |                                                                                                        |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  |  | 21b. TIME OF INJURY                                                                                    |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |  |                                                                     |  |  |
|                                                                                                                                                    |  |  | HOUR A.M. MONTH DAY YEAR                                                                               |  |  |                                                                                                                                                          |  |  |                                                                     |  |  |
| 21d. INJURY OCCURRED                                                                                                                               |  |  | 21e. PLACE OF INJURY                                                                                   |  |  | 21f. LOCATION                                                                                                                                            |  |  |                                                                     |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                  |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                         |  |  | STREET CITY OR TOWN COUNTY STATE                                                                                                                         |  |  |                                                                     |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from                                                                                 |  |  | 19 83 to 19 83, that (I) (we) last                                                                     |  |  |                                                                                                                                                          |  |  |                                                                     |  |  |
| saw the deceased alive on                                                                                                                          |  |  | above, (I) (we) (did) (did not) view the body after death.                                             |  |  |                                                                                                                                                          |  |  |                                                                     |  |  |
| 22b. SIGNATURE                                                                                                                                     |  |  | DEGREE                                                                                                 |  |  | 22c. DATE SIGNED                                                                                                                                         |  |  |                                                                     |  |  |
| Morton L. White, M.D.                                                                                                                              |  |  | Attending Physician                                                                                    |  |  | 20 Oct 1983                                                                                                                                              |  |  |                                                                     |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                              |  |  | 22e. ADDRESS                                                                                           |  |  |                                                                                                                                                          |  |  |                                                                     |  |  |
| Morton L. White, M.D.                                                                                                                              |  |  | 9911 George Ave Silver Spring MD                                                                       |  |  |                                                                                                                                                          |  |  |                                                                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                          |  |  | 23b. DATE                                                                                              |  |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  |  | 23d. LOCATION                                                       |  |  |
| Burial                                                                                                                                             |  |  | 24 1983                                                                                                |  |  | Cedar Hill Cemetery                                                                                                                                      |  |  | Franklin West Virginia                                              |  |  |
| 24. FUNERAL DIRECTOR                                                                                                                               |  |  | 25a. DATE REC'D. BY REGISTRAR                                                                          |  |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                               |  |  |                                                                     |  |  |
| ROBERT A. PUMPHREY FUNERAL HOMES P.A., ROCKVILLE, MARYLAND                                                                                         |  |  | OCT 25 1983                                                                                            |  |  | John J. Carver                                                                                                                                           |  |  |                                                                     |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

FROM THE DIRECTOR, BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

SUBJECT: [Illegible]

[Illegible text follows, appearing to be a memorandum or report.]

[Large block of illegible handwritten text, possibly a list or detailed report, covering the bottom half of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                              |                                  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                              | 2a. DATE OF DEATH MONTH DAY YEAR |                                                                                                                                                             |  | 2b. HOUR                                                                                     |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>PHYLLIS STINEMAN SIMMONS                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                              | OCT 6 1983                       |                                                                                                                                                             |  | 4 30 AM                                                                                      |  |                                                                                                                         |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br>White                                                                                                             |                                  | 5. DATE OF BIRTH MONTH DAY YEAR<br>July 27, 1920                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.                                                   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Altoona, Pa.                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                          |                                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                                       |  |                                                                                                                         |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>9902 Rogart Street |                                  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>At Home                                                                            |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY<br>Montgomery                                                                                                    |                                  | 13c. CITY OR TOWN<br>Silver Spring                                                                                                                          |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>9902 Rogart Rd. 20901                                                                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Eugene Nelson Stineman                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                              |                                  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Edna Lenore Weaver                                                                                            |  |                                                                                              |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>None                                                                 |                                  | 17. INFIRMAN ADDRESS<br>Edwin G. Husband<br>Mr. / Simmons / 9902 Rogart Rd. S. S. Md. 20901                                                                 |  |                                                                                              |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u><br>4960<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC OBSTRUCTIVE LUNG DISEASE</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>and cor pulmonale</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> |  |                                                                                                                              |                                  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Hypertension</u>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                              |                                  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                             |                                  |                                                                                                                                                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                            |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                      |                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                              |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                          |                                  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                              |  |                                                                                                                         |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <u>Jan 19 74</u> to <u>10-6-83</u> , that (I) (we) lost <u>9-30-83</u> above, (I) (we) did (did not) view the body after death.                                                                                                                                                                                                                                                                                             |  |                                                                                                                              |                                  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                         |  |
| 22b. SIGNATURE<br><u>John J. Beiger</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | DEGREE                                                                                                                       |                                  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>10-6-83                                                                  |  |                                                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JASIN BEIGER, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 22e. ADDRESS<br>SP30 CAMERON ST<br>SILVER SPRING, MD. 20910                                                                  |                                  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 23b. DATE<br>Oct. 6, 1983                                                                                                    |                                  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Crematory                                                                                                  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Suitland P. G. Md.                                |  |                                                                                                                         |  |
| 24. FUNERAL DIRECTOR NAME<br>W.W. Chambers Co. Silver Spring, Md.                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                              |                                  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 10 1983                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Beiger</u>                                          |  |                                                                                                                         |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                                      |                                                                                                                                 |                                                                                      |                                                                 |                                                                                                                            | REG. NO.                                                                                  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Andrew Simon</i>                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                          |                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>10 - 2 - 1983</i>          |                                                                                                                                 |                                                                                      | 2b. HOUR<br><i>5:10 PM</i>                                      |                                                                                                                            |                                                                                           |  |
| 3 SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                                                                                     |  | 4 RACE<br><i>White</i>                                                                                                                   |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>3 9 03</i>                                                                                                         |                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>80</i> YRS                                                                                |                                                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |                                                                                                                            |                                                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Hungary</i>                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>                                                                                              |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.                                                                   |                                                                                      |                                                                 |                                                                                                                            |                                                                                           |  |
| 10. CITY OR TOWN OF DEATH<br><i>Sandy Sp. Md.</i>                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Friends Nursing Home</i> |                                                                        |                                                                                                                                                             |                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Nurseryman</i>                                           |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY                               |                                                                                                                            |                                                                                           |  |
| 13a. STATE<br><i>MD.</i>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                          | 13b. COUNTY<br><i>Balt</i>                                             |                                                                                                                                                             | 13c. CITY OR TOWN<br><i>Monkton</i>                                  |                                                                                                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                 | 13e. STREET ADDRESS<br><i>Blue Mountain Rd. 21111</i>                                                                      |                                                                                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Charles Simon</i>                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                          |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Esther Tabor</i> |                                                                                                                                 |                                                                                      |                                                                 |                                                                                                                            |                                                                                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Unknown</i>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                          |                                                                        |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br><i>215-32-9500</i>                       |                                                                                                                                 | 17. INFORMANT<br>ADDRESS<br><i>Friends Nursing Home</i>                              |                                                                 |                                                                                                                            |                                                                                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary Heart Failure</i><br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial Infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis</i> |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                                      |                                                                                                                                 |                                                                                      |                                                                 |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>5A</i><br><i>years</i><br><i>years</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                      |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                                      |                                                                                                                                 |                                                                                      |                                                                 |                                                                                                                            |                                                                                           |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                      |                                                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                 |  |                                                                                                                                          | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                  |                                                                                      |                                                                 |                                                                                                                            |                                                                                           |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                          | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                               |                                                                                      |                                                                 |                                                                                                                            |                                                                                           |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/17</i> 19 <i>76</i> , to <i>10/2</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>9/28</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                              |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                                      |                                                                                                                                 |                                                                                      |                                                                 |                                                                                                                            |                                                                                           |  |
| 22a. SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                                      | DEGREE                                                                                                                          |                                                                                      | 22c. DATE SIGNED<br><i>10/2/83</i>                              |                                                                                                                            |                                                                                           |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Dr. Philip D. Olney</i>                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                                      | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                      |                                                                 |                                                                                                                            |                                                                                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Removal</i>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                                      | 23b. DATE<br><i>10/2/83</i>                                                                                                     |                                                                                      | 23c. NAME OF CEMETERY OR CREMATORY                              |                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Anatomy Board</i>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                                      | ADDRESS<br><i>Balto., Md.</i>                                                                                                   |                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br><i>OGT 7 1983</i>              |                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                          |  |



MEMORANDUM

Blue Mountain Rd. 21111  
////////

2012/03

Report

Blue Mountain Rd. 21111

Inventory Report

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                |  |                               |  |                                                                                                                                     |                                                                   |                                                                                              |  |                                                                                                                                                          |  | REG. NO.                                                                                                                        |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                               |  |                                                                                                                                     |                                                                   |                                                                                              |  |                                                                                                                                                          |  |                                                                                                                                 |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Frank E. Slate</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  |                               |  |                                                                                                                                     |                                                                   |                                                                                              |  |                                                                                                                                                          |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>10 3 19 83</b> |  |
| 3. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE <b>White</b>          |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>July 26 '99</b>                                                                                  |                                                                   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>84 YRS.</b>                                               |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN                                                                                                                     |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>10 3 19 83</b>                                                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  |                               |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                          |                                                                   |                                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>                                                              |  |
| 10. CITY OR TOWN OF DEATH <b>Rockville</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  |                               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Hospital</b> |                                                                   |                                                                                              |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret'd Builder</b>                                                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                               |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                             |  |                               |  |                                                                                                                                     |                                                                   |                                                                                              |  |                                                                                                                                                          |  |                                                                                                                                 |  |
| 13a. STATE <b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY <b>Montgomery</b> |  | 13c. CITY OR TOWN <b>Gaithersburg</b>                                                                                               |                                                                   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>9945 Lake Landing Rd.</b>                                                                                                         |  | 20879                                                                                                                           |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph - Slate</b>                                                                                                                                                                                                                                                                                                                                                                                              |  |                               |  |                                                                                                                                     | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary - Palluzzo</b> |                                                                                              |  |                                                                                                                                                          |  |                                                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                               |  | 16b. SOCIAL SECURITY NO. <b>232-03-5225</b>                                                                                         |                                                                   | 17. INFORMANT <b>Mary Sheridan</b>                                                           |  | ADDRESS <b>9945 Lake Landing Rd. Gaithersburg, Md. 20879</b>                                                                                             |  |                                                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Neck injury</b><br><b>8820</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF                                                                                        |  |                               |  |                                                                                                                                     |                                                                   |                                                                                              |  |                                                                                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Arteriosclerotic cardiovascular disease and senile dementia</b>                                                                                                                                                                                                                                              |  |                               |  |                                                                                                                                     |                                                                   |                                                                                              |  |                                                                                                                                                          |  |                                                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                   |                                                                   |                                                                                              |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                         |  |                                                                                                                                 |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                         |  |                               |  | 21b. TIME OF INJURY HOUR <b>2</b> P.M. MONTH DAY YEAR <b>10 2 19 83</b>                                                             |                                                                   |                                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject fell from window</b>                                            |  |                                                                                                                                 |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                      |  |                               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>nursing home</b>                                                     |                                                                   |                                                                                              |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Collingswood Nursing Home, Rockville, Mont, Md.</b>                                                    |  |                                                                                                                                 |  |
| 22a. I certify that I took charge of the remains described above, held in Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |  |                               |  |                                                                                                                                     |                                                                   |                                                                                              |  |                                                                                                                                                          |  |                                                                                                                                 |  |
| ACTUAL SIGNATURE <b>Thomas D. Smith</b>                                                                                                                                                                                                                                                                                                                                                                                                                |  |                               |  | TITLE (SPECIFY) <b>Deputy Chief</b>                                                                                                 |                                                                   |                                                                                              |  | DATE SIGNED <b>10/4/83</b>                                                                                                                               |  |                                                                                                                                 |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                           |  |                               |  | ADDRESS <b>111 Penn St. Balto., MD.</b>                                                                                             |                                                                   |                                                                                              |  |                                                                                                                                                          |  |                                                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                               |  | 23b. DATE <b>10/7/83</b>                                                                                                            |                                                                   | 23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>                                     |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Montg. Md.</b>                                                                                  |  |                                                                                                                                 |  |
| 24. FUNERAL DIRECTOR <b>Gartner Sandison F.H.</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  |                               |  | ADDRESS <b>316 E. Diamond Ave. Gaithersburg, Md. 20877</b>                                                                          |                                                                   |                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 7 1983</b>                                                                                                          |  |                                                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                               |  |                                                                                                                                     |                                                                   |                                                                                              |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Casper</b>                                                                                                         |  |                                                                                                                                 |  |



RECEIVED  
MAY 12 1964

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MAY 12 1964

100-100000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or REMARKS shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                 |  |                                                                                                           |                                                                        |                                                                                                                                                             |                                                                                                                                            |                                                                                 |                                            |                                                                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                         |  |                                                                                                           |                                                                        |                                                                                                                                                             | REG. NO.                                                                                                                                   |                                                                                 |                                            |                                                                |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                  |  |                                                                                                           |                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH                                                                                                                          |                                                                                 |                                            |                                                                |  |
| FIRST MIDDLE LAST<br>Merton Thomas Smith, Sr.                                                                                                                                                                                                                                                        |  |                                                                                                           |                                                                        |                                                                                                                                                             | MONTH DAY YEAR HOUR<br>10 7 83 9:05 <sup>a</sup>                                                                                           |                                                                                 |                                            |                                                                |  |
| 3. SEX                                                                                                                                                                                                                                                                                               |  | 4. RACE                                                                                                   |                                                                        | 5. DATE OF BIRTH                                                                                                                                            |                                                                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)                                                 |                                            | 7. IF UNDER 1 YEAR                                             |  |
| male                                                                                                                                                                                                                                                                                                 |  | white                                                                                                     |                                                                        | MONTH DAY YEAR<br>11 13 87                                                                                                                                  |                                                                                                                                            | 75 YRS.                                                                         |                                            | MONTHS DAYS HOURS MIN.                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH                                            |                                            |                                                                |  |
| Maryland                                                                                                                                                                                                                                                                                             |  | U.S.A.                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                                                                            | Montgomery MD.                                                                  |                                            |                                                                |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                        |                                                                                                                                                             |                                                                                                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                |                                            | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Rockville                                                                                                                                                                                                                                                                                            |  | Collingswood Nursing Home                                                                                 |                                                                        |                                                                                                                                                             |                                                                                                                                            | laborer                                                                         |                                            | fertilizer & feed                                              |  |
| 13a. STATE                                                                                                                                                                                                                                                                                           |  | 13b. COUNTY                                                                                               |                                                                        | 13c. CITY OR TOWN                                                                                                                                           |                                                                                                                                            | 13d. INSIDE CITY LIMITS?                                                        |                                            | 13e. STREET ADDRESS                                            |  |
| Maryland                                                                                                                                                                                                                                                                                             |  | Frederick                                                                                                 |                                                                        | Union Bridge                                                                                                                                                |                                                                                                                                            | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |                                            | Box 433 21791                                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                               |  |                                                                                                           |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                                                              |                                                                                 |                                            |                                                                |  |
| Thomas H. Smith                                                                                                                                                                                                                                                                                      |  |                                                                                                           |                                                                        |                                                                                                                                                             | Minnie Hatfield                                                                                                                            |                                                                                 |                                            |                                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                     |  |                                                                                                           |                                                                        |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.                                                                                                                   |                                                                                 | 17. INFORMANT ADDRESS                      |                                                                |  |
| No none                                                                                                                                                                                                                                                                                              |  |                                                                                                           |                                                                        |                                                                                                                                                             | 219-14-9014                                                                                                                                |                                                                                 | Elsie Pyles Union Bridge, MD               |                                                                |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>4140 IMMEDIATE CAUSE (a) Congestive Heart failure days<br>(b) ARTERIOSCLEROTIC HEART DIS years<br>(c) ARTERIO SCLEROSIS "                                                                 |  |                                                                                                           |                                                                        |                                                                                                                                                             |                                                                                                                                            |                                                                                 |                                            |                                                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                   |  |                                                                                                           |                                                                        |                                                                                                                                                             |                                                                                                                                            |                                                                                 |                                            |                                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                               |  |                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                                                                            | 20a. AUTOPSY?                                                                   |                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|                                                                                                                                                                                                                                                                                                      |  |                                                                                                           |                                                                        |                                                                                                                                                             |                                                                                                                                            | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |                                            | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                             |  |                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                                                                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) |                                            |                                                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                            |  |                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                                                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |                                            |                                                                |  |
|                                                                                                                                                                                                                                                                                                      |  |                                                                                                           |                                                                        |                                                                                                                                                             |                                                                                                                                            | 8/26/82 to 10/7/83                                                              |                                            |                                                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/26/82 to 10/7/83, that (I) (we) last saw the deceased alive on 10/6/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death.) |  |                                                                                                           |                                                                        |                                                                                                                                                             |                                                                                                                                            |                                                                                 |                                            |                                                                |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                       |  |                                                                                                           |                                                                        |                                                                                                                                                             | DEGREE                                                                                                                                     |                                                                                 | 22c. DATE SIGNED                           |                                                                |  |
| Thos G. Ward, M.D.                                                                                                                                                                                                                                                                                   |  |                                                                                                           |                                                                        |                                                                                                                                                             | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                 | 10/7/83                                    |                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                |  |                                                                                                           |                                                                        |                                                                                                                                                             | 22e. ADDRESS                                                                                                                               |                                                                                 |                                            |                                                                |  |
| Thos G. Ward, 6116 Robinwood, Bethesda, MD 20814                                                                                                                                                                                                                                                     |  |                                                                                                           |                                                                        |                                                                                                                                                             |                                                                                                                                            |                                                                                 |                                            |                                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                            |  |                                                                                                           | 23b. DATE                                                              |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                         |                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |                                                                |  |
| Burial                                                                                                                                                                                                                                                                                               |  |                                                                                                           | 10/10/83                                                               |                                                                                                                                                             | Beaver Dam Cemetery                                                                                                                        |                                                                                 | Union Bridge Fred. MD                      |                                                                |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS                                                                                                                                                                                                                                                                 |  |                                                                                                           |                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR                                                                                                              |                                                                                 | 25b. REGISTRAR'S SIGNATURE                 |                                                                |  |
| S. D. Hartley, Union Bridge, Md.                                                                                                                                                                                                                                                                     |  |                                                                                                           |                                                                        |                                                                                                                                                             | OCT 13 1983                                                                                                                                |                                                                                 | John J. Conner                             |                                                                |  |

BP

North, Thomas, 21-11-9011, Ex. 75

Rockville, 21-11-9011, Ex. 75

Rockville, 21-11-9011, Ex. 75

Rockville, 21-11-9011, Ex. 75

Rockville, 21-11-9011, Ex. 75

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Rockville, 21-11-9011, Ex. 75

Rockville, 21-11-9011, Ex. 75

Rockville, 21-11-9011, Ex. 75

Rockville, 21-11-9011, Ex. 75

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                        |  |                                                                                                                                 |  |                                                                                                                                                              |                                                                                               |                                                                                                                                            |                                               |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                 |  |                                                                                                                                                              | REG. NO.                                                                                      |                                                                                                                                            |                                               |                                                                                                                            |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Mary C. Spann                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                 |  |                                                                                                                                                              | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Oct. 11, 1983                                          |                                                                                                                                            |                                               | 2b. HOUR<br>A<br>2:00 M                                                                                                    |  |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                                             |  | 4 RACE<br>White                                                                                                                 |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>March 13, 1913                                                                                                          |                                                                                               | 6 AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS                                                                                                   |                                               | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                                                                                 |  |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Scotland                                                                                                                                                                                                                                                                                                                         |  | 9a. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                          |  | 9b. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                               | 10 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                                                                              |                                               |                                                                                                                            |  |
| 11 CITY OR TOWN OF DEATH<br>Silver Spring                                                                                                                                                                                                                                                                                                                                   |  | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>121 Eastmoor Drive |  |                                                                                                                                                              |                                                                                               | 13a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Administrative                                                         |                                               | 13b. KIND OF BUSINESS OR INDUSTRY<br>Administration                                                                        |  |
| 14 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>14a. STATE 14b. COUNTY 14c. CITY OR TOWN<br>Maryland Montgomery Silver Spring                                                                                                                                                                                                 |  |                                                                                                                                 |  |                                                                                                                                                              | 15 INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                            | 16 STREET ADDRESS<br>121 Eastmoor Dr. (20901) |                                                                                                                            |  |
| 17 FATHER'S NAME<br>FIRST MIDDLE LAST<br>William - Crawford                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                 |  |                                                                                                                                                              | 18 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen - Shankley                              |                                                                                                                                            |                                               |                                                                                                                            |  |
| 19a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                  |  | 19b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>None                                                                  |  | 20 INFORMANT<br>William C. Spann/400 Greenbriar Dr. Maryland                                                                                                 |                                                                                               | 21 ADDRESS<br>Silver Spring, Maryland                                                                                                      |                                               |                                                                                                                            |  |
| 11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Hepatic Metastases</u><br><u>1629</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Don-small Cell Carcinoma of Lung</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>16mos</u>                                                             |  |                                                                                                                                 |  |                                                                                                                                                              |                                                                                               |                                                                                                                                            |                                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>few mos</u><br><u>16mos</u>                                             |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                          |  |                                                                                                                                 |  |                                                                                                                                                              |                                                                                               |                                                                                                                                            |                                               |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                |  |                                                                                                                                                              |                                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                      |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                            |                                                                                               |                                                                                                                                            |                                               |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                          |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                            |                                                                                               |                                                                                                                                            |                                               |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 10</u> , 19 <u>82</u> , to <u>October 11</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>20 September</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. |  |                                                                                                                                 |  |                                                                                                                                                              |                                                                                               |                                                                                                                                            |                                               |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>G. Lennard Gold</u>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                 |  | DEGREE<br><u>M.D.</u>                                                                                                                                        |                                                                                               | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                               | 22c. DATE SIGNED<br>11 October 83                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>G. Lennard Gold, M.D.                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                 |  | 22e. ADDRESS<br>8630 Fenton Street, Silver Spring, MD                                                                                                        |                                                                                               |                                                                                                                                            |                                               |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br>Oct/11/83                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Crematory                                                                                                   |                                                                                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland, P.G. Co., Maryland                                                                 |                                               |                                                                                                                            |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Chambers Funeral Home Silver Spring, Maryland                                                                                                                                                                                                                                                                                                |  |                                                                                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1983                                                                                                                 |                                                                                               | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Carver</u>                                                                                        |                                               |                                                                                                                            |  |

100-111000

100



*[Handwritten signature]*

On this day...

100-111000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                   |  |                                                                                                                                                           |  |                                                                                                                                                    |  |                                                                                                                                                                                                                                                                          |  | REG. NO.                                                                                                            |  |                                                                                                                                         |  |                                                                                                          |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CHARLES SPECTOR</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                   |  |                                                                                                                                                           |  | 2a. DATE OF DEATH<br>KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>10-22-83</b>                                  |  | 2b. HOUR<br><b>19</b>                                                                                                                                                                                                                                                    |  | 2c. DATE OF DEATH<br>KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>10-22-83</b>   |  | 2d. HOUR<br><b>12:30</b>                                                                                                                |  |                                                                                                          |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br><b>White</b>                                                                                           |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Sept. 15, 1890</b>                                                                                                  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>93</b> YRS.                                                                                                |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                                                                                                                                                                              |  | 8. DATE PRONOUNCED DEAD<br><b>10-22-83</b>                                                                          |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b>                                                                        |  |                                                                                                          |  |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Russia</b>                                                                                                                                                                                                                                                                                                                                                                               |  | 11. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                   |  | 12. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 13. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b>                                                                                  |  | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Tailor</b>                                                                                                                                                                                            |  | 15. KIND OF BUSINESS OR INDUSTRY<br><b>Clothing</b>                                                                 |  | 16. CITY OR TOWN OF DEATH<br><b>Takoma Pk.</b>                                                                                          |  |                                                                                                          |  |
| 17. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Washington Adventist</b>                                                                                                                                                                                                                                                                                    |  | 18. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>New York</b> |  | 19. CITY OR TOWN<br><b>Long Beach</b>                                                                                                                     |  | 20. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                     |  | 21. STREET ADDRESS<br><b>325 East Olive Street</b>                                                                                                                                                                                                                       |  | 22. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Shea Spector</b>                                                       |  | 23. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sussia (Unknown)</b>                                                                |  |                                                                                                          |  |
| 24. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                        |  | 25. SOCIAL SECURITY NO.<br><b>052-01-6643</b>                                                                     |  | 26. INFORMANT<br><b>Sidney Spector (Same as # 13)</b>                                                                                                     |  | 27. ADDRESS<br><b>13</b>                                                                                                                           |  | 28. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Smoke inhalation with complications</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | 29. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                    |  | 30. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |                                                                                                          |  |
| 31. DATE OF OPERATION<br><b>10-23-83</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 32. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>subject in elevator which stopped on floor of fire</b>     |  | 33. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                       |  | 34. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b>8-31-83</b> |  | 35. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>subject in elevator which stopped on floor of fire</b>                                                                                                                                |  | 36. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |  | 37. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>blg.</b>                                                               |  | 38. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>9039 Slig Creek Pkwy. Silver Spring, Maryland</b> |  |
| 39. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from:<br>Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 40. ACTUAL SIGNATURE<br><b>Margarita A. Korell</b>                                                                |  | 41. TITLE (SPECIFY)<br><b>Assistant</b>                                                                                                                   |  | 42. MEDICAL EXAMINER<br><b>M.D. Assistant</b>                                                                                                      |  | 43. DATE SIGNED<br><b>10-23-83</b>                                                                                                                                                                                                                                       |  | 44. EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>                                          |  | 45. ADDRESS<br><b>111 Penn Street</b>                                                                                                   |  | 46. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                             |  |
| 47. DATE<br><b>10/24/1983</b>                                                                                                                                                                                                                                                                                                                                                                                                            |  | 48. NAME OF CEMETERY OR CREMATORY<br><b>Ohev Shalom Talmud Torah Congregation Cemetery</b>                        |  | 49. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, D. C.</b>                                                                                     |  | 50. DATE REC'D. BY REGISTRAR<br><b>OCT 26 1983</b>                                                                                                 |  | 51. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                                                                                                                                                                                                       |  | 52. DONOR OF ORGAN<br><b>Donald M. Stein Hebrew Memorial Funeral Home</b>                                           |  | 53. ADDRESS<br><b>232 Carroll Street, N. W., Washington, D. C.</b>                                                                      |  | 54. DATE REC'D. BY REGISTRAR<br><b>OCT 26 1983</b>                                                       |  |

OFFICE FILES

WIN 2000



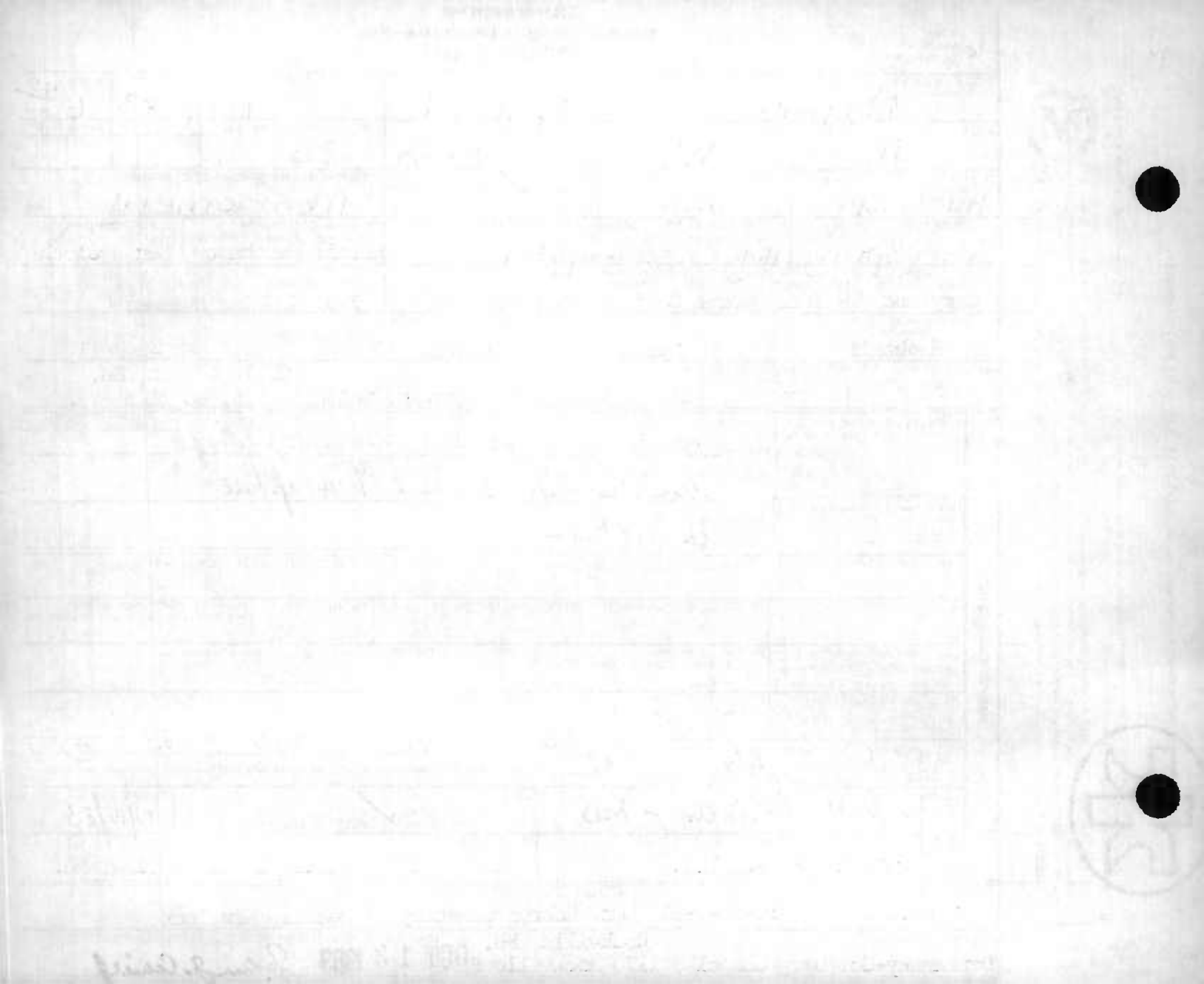
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                      |  | REG. NO.                                                                                                                                                    |  |                                                                                                                         |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                      |  | 2. DATE OF DEATH MONTH DAY YEAR                                                                                                                             |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Maurice Spiegel</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                      |  | 2b. HOUR <b>42</b><br>6 AM                                                                                                                                  |  |                                                                                                                         |  |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br><b>W</b>                                                                                                                  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>7-25-00</b>                                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.                                                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Austria</b>                                                                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                                                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retail Merchant</b>                                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Men's Clothing</b>                                                              |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY<br><b>Prince George</b>                                                                                                  |  | 13c. CITY OR TOWN<br><b>College Park</b>                                                                                                                    |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Naphtali Spiegel</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Rachel Ueberall</b>                                                                 |  | 13e. STREET ADDRESS<br><b>7507 Hopkins Avenue</b>                                                                                                           |  | 20740                                                                                                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                             |  | 16b. SOCIAL SECURITY NO.<br><b>216-12-0778</b>                                                                                       |  | 17. INFORMANT ADDRESS<br><b>Henrietta M. Spiegel; 7507 Hopkins Ave.</b>                                                                                     |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br><b>4349</b> IMMEDIATE CAUSE (a) <b>cardiovascular and respiratory collapse</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>massive left cerebral hemisphere</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>cellular fibrosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                         |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                         |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>9/20</b> , 19 <b>83</b> , to <b>10/10</b> , 19 <b>83</b> , that (1) (we) lost <b>saw the deceased alive on 10/9</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                          |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 22b. SIGNATURE<br><b>Joseph M. Solinas</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  | DEGREE<br><b>MD</b>                                                                                                                  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>10/10/83</b>                                                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOSEPH SOLINAS, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 22e. ADDRESS<br><b>9801 Georgia Avenue; Silver Spring, Md.</b>                                                                       |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 23b. DATE<br><b>10-11-1983</b>                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Hebron Cemetery</b>                                                                                            |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Queens, New York</b>                                                      |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Danzansky-Goldberg Chapels;</b>                                                                                                                                                                                                                                                                                                                                                                            |  | ADDRESS<br><b>1170 Rockville Pike</b>                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 13 1983</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                                                                     |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                           |  |                                                                                                                                        |  | REG. NO.                                                                                                                                      |  |                                                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Grace O. Spradlin</u> <u>Spradlin</u>                                                                                                                                                                                                                                                                   |  |                                                                                                                                        |  | 2a. DATE OF DEATH MONTH <u>10</u> DAY <u>23</u> YEAR <u>83</u>                                                                                |  |                                                                                                                         |  |
| 3. SEX <u>FEMALE</u>                                                                                                                                                                                                                                                                                                                           |  | 4. RACE <u>Caucasian</u>                                                                                                               |  | 5. DATE OF BIRTH MONTH <u>7</u> DAY <u>25</u> YEAR <u>14</u>                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>69</u> YRS.                                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>INDIANA</u>                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                                                                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery County</u> MD.                                                       |  |
| 10. CITY OR TOWN OF DEATH <u>Silver Spring</u>                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>St. Elizabeth's Hospital</u> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Accountant</u>                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>                                                                  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                        |  |                                                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                  |  |                                                                                                                         |  |
| 13a. STATE <u>Maryland</u>                                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY <u>Montgomery</u>                                                                                                          |  | 13c. CITY OR TOWN <u>Silver Spring</u>                                                                                                        |  | 13e. STREET ADDRESS <u>3548 Chiswick Court</u> <u>20906</u>                                                             |  |
| 14. FATHER'S NAME FIRST <u>Henry</u> MIDDLE <u></u> LAST <u>Orr</u>                                                                                                                                                                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME FIRST <u>Lucille</u> MIDDLE <u></u> LAST <u>Latz</u>                                                          |  |                                                                                                                                               |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO. <u>011-01-6698</u>                                                                                            |  | 17. INFORMANT ADDRESS <u>William H. Spradlin Husband</u> <u>Same as 13</u>                                                                    |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                          |  |                                                                                                                                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                  |  |                                                                                                                         |  |
| IMMEDIATE CAUSE (a) <u>Hemorrhage / Shock</u>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        |  |                                                                                                                                               |  |                                                                                                                         |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>1509</u>                                                                                                                                                                                                                                     |  |                                                                                                                                        |  |                                                                                                                                               |  |                                                                                                                         |  |
| (b) <u>Esophageal Cancer</u>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        |  |                                                                                                                                               |  |                                                                                                                         |  |
| (c) <u></u>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                        |  |                                                                                                                                               |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>COPD</u>                                                                                                                                                                                                   |  |                                                                                                                                        |  |                                                                                                                                               |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION <u>2/9</u>                                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Esophageal Cancer</u>                                                              |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                             |  | 21b. TIME OF INJURY HOUR <u></u> A.M. <u></u> MONTH <u></u> DAY <u></u> YEAR <u>19</u> P.M. <u></u>                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                       |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                    |  | 21f. LOCATION STREET <u></u> CITY OR TOWN <u></u> COUNTY <u></u> STATE <u></u>                                                                |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u></u> , 19 <u></u> to <u></u> , 19 <u></u> , that (I) (we) last saw the deceased alive on <u></u> , 19 <u></u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                        |  |                                                                                                                                               |  |                                                                                                                         |  |
| 22b. SIGNATURE <u>David B. Vroman</u> DEGREE <u>M.D.</u>                                                                                                                                                                                                                                                                                       |  |                                                                                                                                        |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>    |  | 22c. DATE SIGNED                                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>David B. Vroman</u>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        |  | 22e. ADDRESS <u>12006 Veirs Mill Road</u> <u>Wheaton, Md</u>                                                                                  |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>                                                                                                                                                                                                                                                                                     |  | 23b. DATE <u>Oct. 26, 1983</u>                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Metropolitan Crematory</u> <u>Alexandria</u> <u>Va.</u>                                                 |  | 23d. LOCATION CITY OR TOWN <u></u> COUNTY <u></u> STATE <u></u>                                                         |  |
| 24. FUNERAL DIRECTOR <u>Francis J. Collins</u> NAME, ADDRESS <u>500 University Blvd., W. Silver Spring, Md.</u>                                                                                                                                                                                                                                |  |                                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR <u>OCT 27 1983</u>                                                                                              |  | 25b. REGISTRAR'S SIGNATURE <u>John J. Collins</u>                                                                       |  |

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CHIEF OF POLICE

NEW YORK CITY

OFFICE OF THE CHIEF OF POLICE

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CHIEF OF POLICE

NEW YORK CITY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                         |  | REG. NO.                                                                                                                                                    |  |                                                                                                                            |                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                                            |                                                                                |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JEAN MARCELLA STAMATI</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                         |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10-7-83</b>                                                                                                       |  | 2b. HOUR<br>P<br><b>2:30 M</b>                                                                                             |                                                                                |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br><b>CAUC.</b>                                                                                                                 |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JAN 10, 1895</b>                                                                                                   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.                                                                          |                                                                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENN.</b>                                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                                              |                                                                                |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b>                                                                        |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                                                |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                                            |                                                                                |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY<br><b>MONT.</b>                                                                                                             |  | 13c. CITY OR TOWN<br><b>WHEATON</b>                                                                                                                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                                                                |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN BOWOLSKI</b>                                                                                    |  |                                                                                                                            |                                                                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>263-42-5556</b>                                                           |  | 17. INFORMANT<br><b>HARRIET C. SIMOULES</b>                                                                                                                 |  | ADDRESS<br><b>SAME AS 13</b>                                                                                               |                                                                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Massive Cerebrovascular Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                           |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b><br><b>1 week</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>HYPERTHYROIDISM, ATRIAL FIBRILLATION, DIARRHEA, WEIGHT LOSS</b>                                                                                                                                                                                                                |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                                            |                                                                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                        |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                                            |                                                                                |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |                                                                                |
| 22a. I certify that (I) ( <del>XXXXX</del> ) attended the deceased from <b>9/15</b> , 19 <b>83</b> , to <b>10/7</b> , 19 <b>83</b> , that (I) ( <del>X</del> ) last saw the deceased alive on <b>10/7</b> , 19 <b>83</b> , and that in (my) ( <del>my</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) ( <del>not</del> ) view the body after death. |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                                            |                                                                                |
| 22b. SIGNATURE<br><b>Daniel Rosenblum, MD</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                         |  | DEGREE<br><b>MD</b>                                                                                                                                         |  | 22c. DATE SIGNED<br><b>10/7/83</b>                                                                                         |                                                                                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Daniel Rosenblum, MD</b>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                         |  | 22e. ADDRESS<br><b>10400 Connecticut Avenue St 606 Kensington, Md. 20895</b>                                                                                |  |                                                                                                                            |                                                                                |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br><b>OCT. 11, 1983</b>                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GATE OF HEAVEN Cem</b>                                                                                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>STL. SPG. MONT. MD.</b>                                                   |                                                                                |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b>                                                                                                                                                                                                                                                                                                                                                             |  | ADDRESS<br><b>500 UNIV. BLVD W. SIL. SPG. MD. 20901</b>                                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 13 1983</b>                                                                                                         |  |                                                                                                                            |                                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                         |  | REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                                                                                                              |  |                                                                                                                            |                                                                                |

FRANCIS J. COLLINS 21L 2PG. MD. 20901  
500 UNIV. BLVD W.  
OCT. 11, 1983 GATE OF HEAVEN  
21L 2PG. MD. 20901

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR                                                                       |                                   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                         |                                                                                                        | MONTH DAY YEAR                                                                                                                                           |                                                                     | HOURS MIN.                                                                     |                                   |
| Connie ELIZABETH STATLAND                                                                                                                                                                                                                                                                                                   |                                                                                                        | 10 2 83                                                                                                                                                  |                                                                     | 9:45 P.M.                                                                      |                                   |
| 3. SEX                                                                                                                                                                                                                                                                                                                      | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR                                                                |                                   |
| Female                                                                                                                                                                                                                                                                                                                      | White                                                                                                  | MONTH DAY YEAR                                                                                                                                           | 79                                                                  | MONTHS DAYS HOURS MIN.                                                         |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                   | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                                                                |                                   |
| North Carolina                                                                                                                                                                                                                                                                                                              | U.S.A.                                                                                                 |                                                                                                                                                          | Montgomery MD.                                                      |                                                                                |                                   |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY |
| Takoma Park                                                                                                                                                                                                                                                                                                                 | Washington Adventist Hospital                                                                          |                                                                                                                                                          | Housewife                                                           |                                                                                |                                   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                   |
| 13a. STATE                                                                                                                                                                                                                                                                                                                  | 13b. COUNTY                                                                                            | 13c. CITY OR TOWN                                                                                                                                        | 13d. INSIDE CITY LIMITS?                                            | 13e. STREET ADDRESS                                                            |                                   |
| Maryland                                                                                                                                                                                                                                                                                                                    | Montgomery                                                                                             | Silver Spring                                                                                                                                            | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20910 8011 Eastern Avenue #104                                                 |                                   |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                           |                                                                                                        | 15. MOTHER'S MAIDEN NAME                                                                                                                                 |                                                                     | ADDRESS                                                                        |                                   |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                           |                                                                                                        | FIRST MIDDLE LAST                                                                                                                                        |                                                                     | ADDRESS                                                                        |                                   |
| John Edward Simpson                                                                                                                                                                                                                                                                                                         |                                                                                                        | Sarah Ellen Stegall                                                                                                                                      |                                                                     | 4705 Aspen Hill Road                                                           |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                           |                                                                                                        | 16b. SOCIAL SECURITY NO.                                                                                                                                 |                                                                     | 17. INFORMANT                                                                  |                                   |
| No                                                                                                                                                                                                                                                                                                                          |                                                                                                        | 578-03-2828                                                                                                                                              |                                                                     | Son Michael I. Statland                                                        |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory arrest                                                                                                                                                                         |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                   |
| 3314 DUE TO, OR AS A CONSEQUENCE OF (b) Sub-arachnoid haemorrhage                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                   |
| DUE TO, OR AS A CONSEQUENCE OF (c) Hydrocephalus                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                      |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                                     | 20a. AUTOPSY?                                                                  |                                   |
|                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                                     | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                          |                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                                     |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                    |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                     | 21f. LOCATION CITY OR TOWN COUNTY STATE                                        |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/23/83, 19 83, to 10/2/83, 19 83, that (I) (we) last saw the deceased alive on 10/1/83, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                                |                                   |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                              |                                                                                                        | DEGREE                                                                                                                                                   |                                                                     | 22c. DATE SIGNED                                                               |                                   |
| Tony P. Kannerkat                                                                                                                                                                                                                                                                                                           |                                                                                                        | MD                                                                                                                                                       |                                                                     | 10/3/83                                                                        |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                       |                                                                                                        | 22e. ADDRESS                                                                                                                                             |                                                                     |                                                                                |                                   |
| TONY P. KANNERKAT, MD                                                                                                                                                                                                                                                                                                       |                                                                                                        | 8201 16th ST Silver Spring MD 20910                                                                                                                      |                                                                     |                                                                                |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                   |                                                                                                        | 23b. DATE                                                                                                                                                |                                                                     | 23c. NAME OF CEMETERY OR CREMATORY                                             |                                   |
| Burial                                                                                                                                                                                                                                                                                                                      |                                                                                                        | Oct. 5, 1983                                                                                                                                             |                                                                     | Cedar Hill Cemetery                                                            |                                   |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                   |                                                                                                        | 24b. ADDRESS                                                                                                                                             |                                                                     | 24c. DATE REC'D. BY REGISTRAR                                                  |                                   |
| Francis J. Collins                                                                                                                                                                                                                                                                                                          |                                                                                                        | 500 University Blvd., W. Silver Spring, Md.                                                                                                              |                                                                     | 10/6/83                                                                        |                                   |
| 24d. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                  |                                                                                                        | 24e. REGISTRAR'S SIGNATURE                                                                                                                               |                                                                     |                                                                                |                                   |
| John J. Gough                                                                                                                                                                                                                                                                                                               |                                                                                                        | John J. Gough                                                                                                                                            |                                                                     |                                                                                |                                   |

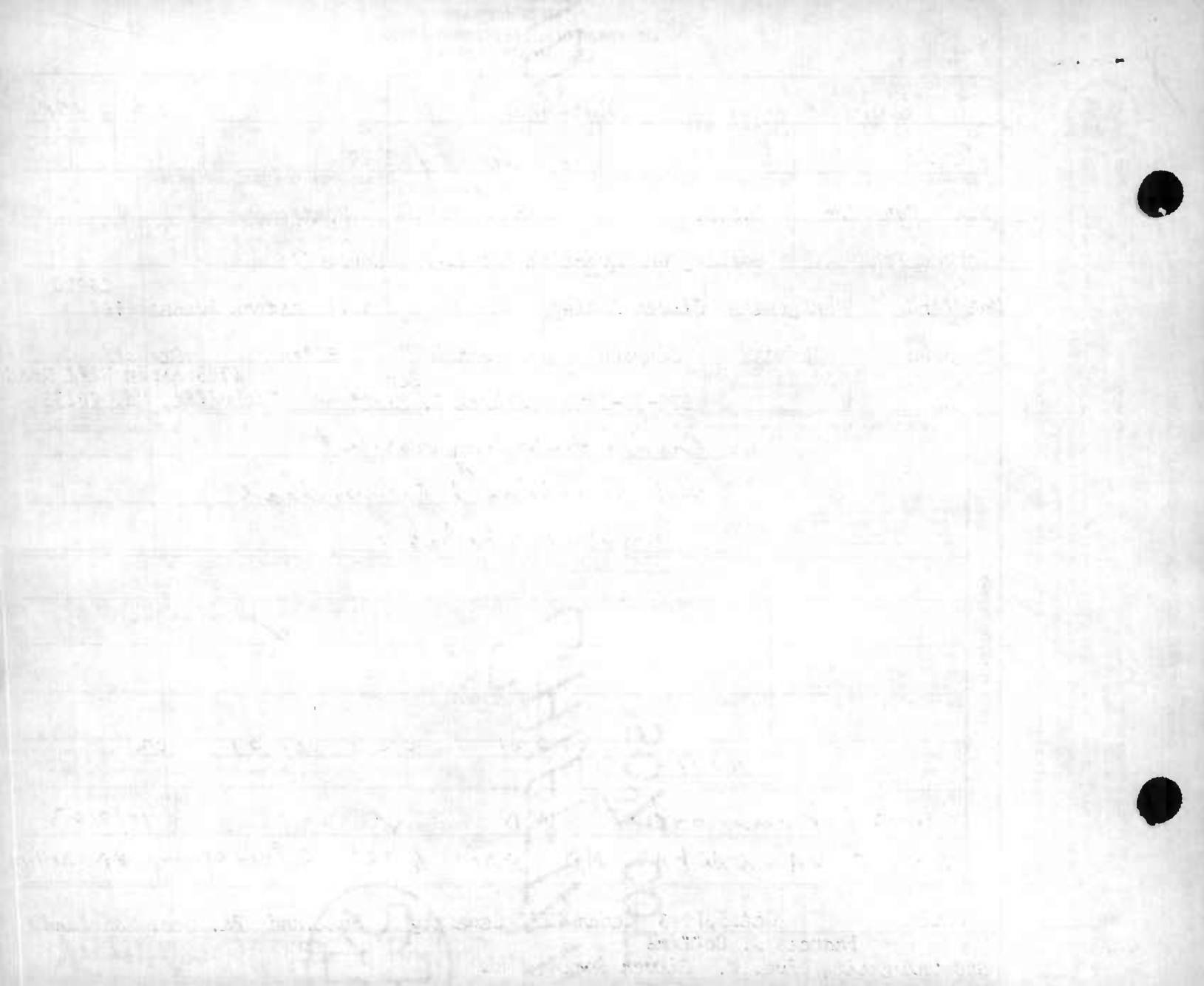
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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shown any injury, or other traumatic event, the medical certificate must be certified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                |  |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |                                                           |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                |  |                                                                                                                                                             | REG. NO.                                                                             |                                                                                                 |                                                                                                                            |                                                           |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>FLOSSIE STERN                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br>OCT. 14, 1983 11:45 AM                  |                                                                                                 |                                                                                                                            |                                                           |  |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>WHITE                                                                                                               |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>DEC. 24 1891                                                                                                          |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS. 91                                                   |                                                                                                                            | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW YORK CITY                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD                                           |                                                                                                                            |                                                           |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SUBURBAN HOSPITAL |  |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER        |                                                                                                 |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOME                 |  |
| 13a. STATE<br>MD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY<br>MONTGOMERY                                                                                                      |  | 13c. CITY OR TOWN<br>ROCKVILLE                                                                                                                              |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS / ZIP CODE<br>6121 MONTROSE RD. 20852 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>MICHAEL MARKS                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>FRANCES HOISHE                      |                                                                                                 |                                                                                                                            |                                                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>NONE                                                                |  | 17. INFORMANT<br>1819 TUFFA TERRACE<br>MARC SHEINBERG SILVER SPRING, MD                                                                                     |                                                                                      |                                                                                                 |                                                                                                                            |                                                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>5609<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Sepsis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Small bowel gangrene</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 weeks</u><br><u>2 weeks</u> |  |                                                                                                                                |  |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |                                                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Renal failure</u>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                |  |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |                                                           |  |
| 19a. DATE OF OPERATION<br>10/2/83                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Gallstone ileus, bowel obstruction                                         |  |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)                                                                              |                                                                                      |                                                                                                 |                                                                                                                            |                                                           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                                                 |                                                                                                                            |                                                           |  |
| 22a. I certify that (1) this hospital attended the deceased from 9/29/83 to 10/14/83, that (2) we lost<br>saw the deceased alive on 10/13/83, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If we) did (did not) view the body after death.                                                                                                                                                                                     |  |                                                                                                                                |  |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |                                                           |  |
| 22b. SIGNATURE<br>ROBERT L. ROSENBERG, MD                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | DEGREE<br>MD                                                                                                                   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                                                                                      | 22c. DATE SIGNED<br>10/14/83                                                                    |                                                                                                                            |                                                           |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br>10-16-83                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. SINAI CEMETERY                                                                                                    |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>PHILADELPHIA, PA.                                 |                                                                                                                            |                                                           |  |
| 24. FUNERAL DIRECTOR<br>DANZANSKY-GOLDBERG MEM. CHP                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 1170 ROCKVILLE PK. ROCKVILLE MD                                                                                                |  | DATE REC'D BY REGISTRAR<br>OCT 19 1983                                                                                                                      |                                                                                      | REGISTRAR'S SIGNATURE<br>John J. Carver                                                         |                                                                                                                            |                                                           |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the local health department. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                                                                                      |                                                                              |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Melvan Susie Settles</b>                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 10 83</b>                 |                                                                                                                                                             |                                                                                                 | 2b. HOUR<br><b>5:25 PM</b>                                                                                                                           |                                                                              |                                                                                                                            |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>Black</b>                                                                                                                           |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>December 13, 1924</b>                                                                                              |                                                                                                 | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>58</b>                                                                                                       |                                                                              | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Illinois</b>                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                     |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                                                                        |                                                                              |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hospital</b> |                                                                        |                                                                                                                                                             |                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Payroll</b>                                                                   |                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Donoley Phone Books</b>                                                            |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                    |  |                                                                                                                                                   | 13b. CITY OR TOWN<br><b>P.G.</b>                                       |                                                                                                                                                             | 13c. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                                                                      | 13d. STREET ADDRESS<br><b>5003 LeeJay Drive 20743</b>                        |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Abraham Martin</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Veinina Lewis</b>  |                                                                                                                                                             |                                                                                                 | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                        |                                                                              |                                                                                                                            |  |
| 16b. SOCIAL SECURITY NO.<br><b>343-20-2028</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                   | 17. INFORMANT<br><b>Karen Settles</b>                                  |                                                                                                                                                             |                                                                                                 | ADDRESS <b>1102 Baiboa Ave. Capitol Heights, Md. 20743</b>                                                                                           |                                                                              |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septic Shock</b><br>4860<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneumonia + Urinary Tract Infection</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                                                                                      |                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Chronic Organic Brain Syndrome, Seizure disorder</b>                                                                                                                                                                                                 |  |                                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                                                                                      |                                                                              |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |                                                                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                    |  |                                                                                                                                                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                                              |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                              |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/10</b> 19 <b>83</b> , to <b>10/10</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>10/10</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |                                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                                                                                      |                                                                              |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Antonio G. Uy</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                                                 | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                              | 22c. DATE SIGNED<br><b>Oct. 10, 1983</b>                                                                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANTONIO G. Uy MD.</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                                                 | 22e. ADDRESS<br><b>831 Linn Blvd E #28 SS Rd 20903</b>                                                                                               |                                                                              |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                   | 23b. DATE<br><b>Oct. 14, 1983</b>                                      |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington Natl. Cem.</b>                               |                                                                                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlington Arlington Va.</b> |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1983</b>                                                                                                  |                                                                              |                                                                                                                            |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                                                                                      |                                                                              |                                                                                                                            |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                |                                               |                                                                                                                                         |                                                                                                                                                             |                                                                                | REG. NO.                                                                                                                                                                                                    |                                                                                |                                                                                                                            |                                                |                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|---------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNIE Bidgood STINETTE</b>                                                                                                                                                                                                                                                                                                                                                                                                   |                                               |                                                                                                                                         |                                                                                                                                                             |                                                                                | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>31</b> YEAR <b>83</b>                                                                                                                                           |                                                                                |                                                                                                                            |                                                | 2b. HOUR<br><b>3:48 A</b> |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             | 4. RACE<br><b>White</b>                       | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>01</b> YEAR <b>1919</b>                                                                      |                                                                                                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.                              |                                                                                                                                                                                                             | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                                 |                                                                                                                            | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> |                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |                                                                                                                                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                                                                                                                               |                                                                                |                                                                                                                            |                                                |                           |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSPITAL</b> |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Contract Spec.</b>                                                                                                                   |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Navy Dept.</b>                                                                     |                                                |                           |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                             |                                               |                                                                                                                                         |                                                                                                                                                             |                                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                             |                                                                                |                                                                                                                            |                                                |                           |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       | 13b. COUNTY<br><b>Montgomery</b>              | 13c. CITY OR TOWN<br><b>Silver Spring</b>                                                                                               |                                                                                                                                                             | 13e. STREET ADDRESS<br><b>1901 Plyers Mill Road 20902</b>                      |                                                                                                                                                                                                             |                                                                                |                                                                                                                            |                                                |                           |
| 14. FATHER'S NAME<br>FIRST <b>Phillip</b> MIDDLE <b></b> LAST <b>Bidgood</b>                                                                                                                                                                                                                                                                                                                                                                                        |                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ethel</b> MIDDLE <b>A.</b> LAST <b>Ayre</b>                                                        |                                                                                                                                                             |                                                                                | ADDRESS<br><b>4513 Guilford Road College Park, Md</b>                                                                                                                                                       |                                                                                |                                                                                                                            |                                                |                           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                                                                                                                      |                                               | 16b. SOCIAL SECURITY NO.<br><b>579-12-4661</b>                                                                                          |                                                                                                                                                             | 17. INFORMANT<br><b>Daughter</b><br><b>Eileen A. Ehrensberger</b>              |                                                                                                                                                                                                             |                                                                                |                                                                                                                            |                                                |                           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>2898 PSEUDOMONAS SEPTICEMIA</b><br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>PRE-LEUKEMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>ONE WEEK</b><br><b>5 MONTHS</b> |                                               |                                                                                                                                         |                                                                                                                                                             |                                                                                | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).<br><b>ADULT RESPIRATORY DISTRESS SYNDROME; CONSUMPTION COAGULOPATHY</b> |                                                                                |                                                                                                                            |                                                |                           |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                        |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                   |                                                                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                |                           |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                            |                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                       |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                                                                                                             |                                                                                |                                                                                                                            |                                                |                           |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                        |                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                                                                                                             |                                                                                |                                                                                                                            |                                                |                           |
| 22a. I certify that (1) this hospital attended the deceased from <b>JULY 25 1978</b> , to <b>10/31 1983</b> , that (1) (we) last saw the deceased alive on <b>10/30 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.                                                                                                                             |                                               |                                                                                                                                         |                                                                                                                                                             |                                                                                |                                                                                                                                                                                                             |                                                                                |                                                                                                                            |                                                |                           |
| 22b. SIGNATURE<br><b>Martin C. Shargel</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |                                               | DEGREE<br><b>M.D.</b>                                                                                                                   |                                                                                                                                                             |                                                                                | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                                                  |                                                                                |                                                                                                                            | 22c. DATE SIGNED<br><b>10/31/83</b>            |                           |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARTIN C. SHARGEL</b>                                                                                                                                                                                                                                                                                                                                                                                                   |                                               |                                                                                                                                         |                                                                                                                                                             | 22e. ADDRESS<br><b>3720 FARRAGUT AVE. KENSINGTON, MD - 20895</b>               |                                                                                                                                                                                                             |                                                                                |                                                                                                                            |                                                |                           |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                       |                                               | 23b. DATE<br><b>Nov. 4, 1983</b>                                                                                                        |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>George Washington</b>                 |                                                                                                                                                                                                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Adelphi Pr. Geo. Maryland</b> |                                                                                                                            |                                                |                           |
| 24. FUNERAL DIRECTOR<br>NAME <b>Francis J. Collins</b> ADDRESS<br><b>500 University Blvd., W. Silver Spring, Md.</b>                                                                                                                                                                                                                                                                                                                                                |                                               |                                                                                                                                         |                                                                                                                                                             |                                                                                | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 2 1983</b>                                                                                                                                                          |                                                                                |                                                                                                                            |                                                |                           |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Collins</b>                                                                                                                                                                                                                                                                                                                                                                                                                |                                               |                                                                                                                                         |                                                                                                                                                             |                                                                                |                                                                                                                                                                                                             |                                                                                |                                                                                                                            |                                                |                           |

BP

DATE 10-23-54

TO: Mr. J. Edgar Hoover

FROM: Mr. [illegible]

SUBJECT: [illegible]

RE: [illegible]

Enclosed for the Bureau are two copies of a letterhead memorandum dated and captioned as above.

Very truly yours,

[illegible signature]

Special Agent in Charge

FBI - [illegible]

10-23-54

10-23-54

10-23-54

10-23-54

10-23-54

10-23-54

10-23-54



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                            |  |                                                                                                                                  |  |                                                                                              |  |                                                                                                                                                             |  |                                                                                                  |  |                                                               |  |  |  |  |  |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                            |  |                                                                                                                                  |  |                                                                                              |  |                                                                                                                                                             |  | 27871                                                                                            |  |                                                               |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>FAUSTINO REYNES SUAREZ</b>                                                                                                                                                                                                                                                                                                                                                            |  |                            |  |                                                                                                                                  |  |                                                                                              |  |                                                                                                                                                             |  | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR<br><input checked="" type="checkbox"/> <b>Oct. 1 1983</b> |  |                                                               |  |  |  |  |  |  |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>CAUC.</b>    |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>FEB. 15, 1929</b>                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br><b>54 YRS.</b>                                |  | IF UNDER 1 YR. MONTHS DAYS                                                                                                                                  |  | IF UNDER 24 HRS. HOURS MIN                                                                       |  | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br><b>Oct. 1 1983</b> |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Philippines</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Philippines</b>                                                                               |  |                                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                                                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery MD.</b> |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  |                            |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3812 Wilberbst</b> |  |                                                                                              |  | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)<br><b>Professor-Doctor</b>                                                                    |  |                                                                                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Medical Sch.</b>      |  |  |  |  |  |  |  |
| 13a. STATE<br><b>Md</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY<br><b>Mont</b> |  | 13c. CITY OR TOWN<br><b>Olney</b>                                                                                                |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3812 Wilberbst</b>                                                                                                                |  |                                                                                                  |  |                                                               |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Estanislao - Suarez</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                            |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Rosario - Reynes</b>                                                            |  |                                                                                              |  |                                                                                                                                                             |  |                                                                                                  |  |                                                               |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                |  |                            |  | 16b. SOCIAL SECURITY NO.<br><b>215-42-1135</b>                                                                                   |  | 17. INFORMANT<br><b>Patricia Suarez</b>                                                      |  |                                                                                                                                                             |  | ADDRESS<br><b>Same as # 13</b>                                                                   |  |                                                               |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>11 mo</b>            |  |                            |  |                                                                                                                                  |  |                                                                                              |  |                                                                                                                                                             |  |                                                                                                  |  |                                                               |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>None</b>                                                                                                                                                                                                                                                                                             |  |                            |  |                                                                                                                                  |  |                                                                                              |  |                                                                                                                                                             |  |                                                                                                  |  |                                                               |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>None</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  |                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                |  |                                                                                              |  |                                                                                                                                                             |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |  |                                                               |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                            |  |                            |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                   |  |                                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                  |  |                                                               |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                       |  |                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                      |  |                                                                                              |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                  |  |                                                               |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                            |  |                                                                                                                                  |  |                                                                                              |  |                                                                                                                                                             |  |                                                                                                  |  |                                                               |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>John S. Rogers</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  |                            |  | TITLE (SPECIFY)<br><b>M.D. Dep.</b>                                                                                              |  |                                                                                              |  | MEDICAL EXAMINER<br><b>Silver Spring, Md.</b>                                                                                                               |  |                                                                                                  |  | DATE SIGNED<br><b>Oct. 1, 1983</b>                            |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>John S. Rogers, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                            |  | ADDRESS<br><b>Silver Spring, Md.</b>                                                                                             |  |                                                                                              |  |                                                                                                                                                             |  |                                                                                                  |  |                                                               |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                            |  | 23b. DATE<br><b>Oct. 2, 1983</b>                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee Crematory</b>                                   |  |                                                                                                                                                             |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Washington, D. C.</b>                              |  |                                                               |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Francis H. Barber</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |                            |  |                                                                                                                                  |  | ADDRESS<br><b>Laytonsville, Md. 20879</b>                                                    |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 6 1983</b>                                               |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>           |  |  |  |  |  |  |  |

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

RECEIVED

WIND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                    |                                                                                                                                                |                                                                                                                                                             |                                                                                                                   |  |                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Alma E. Surmo</b>                                                                                                                                           |                                                                                                                                                |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>1</b> YEAR <b>83</b> 7b. HOUR <b>4<sup>25</sup></b> <b>P</b> <b>M</b> |  |                                                   |
| 3. SEX<br><b>Female</b>                                                                                                                                                                            | 4. RACE<br><b>White</b>                                                                                                                        | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>16</b> YEAR <b>05</b>                                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.                                                                 |  | 7b. HOUR <b>4<sup>25</sup></b> <b>P</b> <b>M</b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                                                                                                                                   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                                     |  |                                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>                                                                                                                                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hosp.</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Legal Secretary</b>                         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Legal</b> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Pennsylvania</b> 13a. COUNTY <b>West Newton</b> 13a. CITY OR TOWN <b>West Newton</b> |                                                                                                                                                |                                                                                                                                                             | 13b. STREET ADDRESS<br><b>P.O. BOX 246 15089</b>                                                                  |  |                                                   |
| 14. FATHER'S NAME<br>FIRST <b>Henry</b> MIDDLE <b>Bleich</b> LAST <b>unknown</b>                                                                                                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>unknown</b> MIDDLE <b>unknown</b> LAST <b>unknown</b>                                                     |                                                                                                                                                             | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)        |  |                                                   |
| 16b. SOCIAL SECURITY NO.<br><b>377-05-4290</b>                                                                                                                                                     |                                                                                                                                                |                                                                                                                                                             | 17. INFORMANT<br><b>Harry E. Stine</b> ADDRESS <b>10217 Ridgemoor Dr. Silver Spring, Maryland 20901</b>           |  |                                                   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CEREBRO VASCULAR ACCIDENT**  
**4360**  
DUE TO, OR AS A CONSEQUENCE OF  
(b) **Arteriosclerosis**  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **no**

MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                          |                                                                       |                                                                                                                                            |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-30-83</b> to <b>10-1-83</b> that (I) (we) last saw the deceased alive on <b>9-30-83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                                                                       |                                                                                                                                            |                                                                                                                            |
| 22b. SIGNATURE<br><b>M Snow MD</b>                                                                                                                                                                                                                                                                                       | DEGREE                                                                | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>10.1.83</b>                                                                                         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M SNOW MD</b>                                                                                                                                                                                                                                                                |                                                                       | 22e. ADDRESS<br><b>9013 FLOWER AVE SILVER SPRING MD 20901</b>                                                                              |                                                                                                                            |

|                                                               |                             |                                                                                         |                                            |
|---------------------------------------------------------------|-----------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b> | 23b. DATE<br><b>10/1/83</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crematory Alexandria Virginia</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |
| 24. FUNERAL DIRECTOR<br>NAME <b>Francis J. Collins</b>        |                             | 25. DATE REC'D. BY REGISTRAR <b>001-6 1983</b>                                          |                                            |
| 500 University Blvd. W. Silver Spring, Md. 20901              |                             | REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>                                          |                                            |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of on

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                    |  |                                                                                                                                                          |                                                     |                                                                                              |  |                                                                                                                                            |  |                                                                                                                         |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                    |  |                                                                                                                                                          | REG. NO.                                            |                                                                                              |  |                                                                                                                                            |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>EMILY Elizabeth SWAGART</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                    |  |                                                                                                                                                          | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>10 24 83</i> |                                                                                              |  |                                                                                                                                            |  | 2b. HOUR<br><i>8 A M</i>                                                                                                |  |
| 3. SEX<br><i>Female</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><i>Caucasian</i>                                                                                                                        |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>April 10 1892</i>                                                                                                  |                                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>91</i> YRS.                                            |  | IF UNDER 1 YEAR MONTHS DAYS                                                                                                                |  | IF UNDER 24 HRS. HOURS MIN.                                                                                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Washington, D. C.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                                      |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.                                |  |                                                                                                                                            |  |                                                                                                                         |  |
| 10. CITY OR TOWN OF DEATH<br><i>Kensington</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Kensington Gardens Nursing Center</i> |  |                                                                                                                                                          |                                                     | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                          |  |                                                                                                                         |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                    |  |                                                                                                                                                          |                                                     |                                                                                              |  |                                                                                                                                            |  |                                                                                                                         |  |
| 13a. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 13b. COUNTY<br><i>Montgomery</i>                                                                                                                   |  | 13c. CITY OR TOWN<br><i>Chevy Chase</i>                                                                                                                  |                                                     | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>8783 Preston Place 20815</i>                                                                                     |  |                                                                                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>George Jeffries</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Eliza Williams</i>                                                                                      |                                                     |                                                                                              |  |                                                                                                                                            |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br><i>577-28-2603</i>                                                                                                           |                                                     | 17. INFORMANT ADDRESS<br><i>John M. Swagart Son Same as 13</i>                               |  |                                                                                                                                            |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Heart Failure</i><br><i>4140</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Arteriosclerotic heart disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Generalized arteriosclerosis</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>12 hours</i><br><i>3 years</i><br><i>15 years</i> |  |                                                                                                                                                    |  |                                                                                                                                                          |                                                     |                                                                                              |  |                                                                                                                                            |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><i>Chronic upper G.I. bleeding.</i>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                    |  |                                                                                                                                                          |                                                     |                                                                                              |  |                                                                                                                                            |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                     |                                                                                              |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                    |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>9-22 82</i> P.M. <i>19 83</i>                                                                         |                                                     |                                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                    |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                     |                                                                                              |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                             |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9-22 82</i> to <i>10-24 83</i> , that (I) (we) last saw the deceased alive on <i>10-5 83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                                    |  |                                                                                                                                                    |  |                                                                                                                                                          |                                                     |                                                                                              |  |                                                                                                                                            |  |                                                                                                                         |  |
| 22b. SIGNATURE<br><i>James C. Mandes</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                    |  | DEGREE<br><i>M.D.</i>                                                                                                                                    |                                                     |                                                                                              |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>10-24-83</i>                                                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>JAMES C. MANDES MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                    |  | 22e. ADDRESS<br><i>1631 16th ST. N.W. WASH. D.C.</i>                                                                                                     |                                                     |                                                                                              |  |                                                                                                                                            |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                    |  | 23b. DATE<br><i>Oct. 27, 1983</i>                                                                                                                        |                                                     | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Olivet Cemetery</i>                             |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Washington, D. C.</i>                                                                        |  |                                                                                                                         |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Francis J. Collins</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                    |  |                                                                                                                                                          |                                                     | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 27 1983</i>                                          |  |                                                                                                                                            |  |                                                                                                                         |  |
| 500 University Blvd., W. Silver Spring, Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                    |  |                                                                                                                                                          |                                                     | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i>                                          |  |                                                                                                                                            |  |                                                                                                                         |  |

BP

TO : SAC, NEW YORK (100-158841)  
FROM : SAC, NEW YORK (100-158841) (P)  
SUBJECT: [Illegible]

[Extremely faint, illegible body text consisting of several paragraphs.]



CHIEF IN CHARGE

POST OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

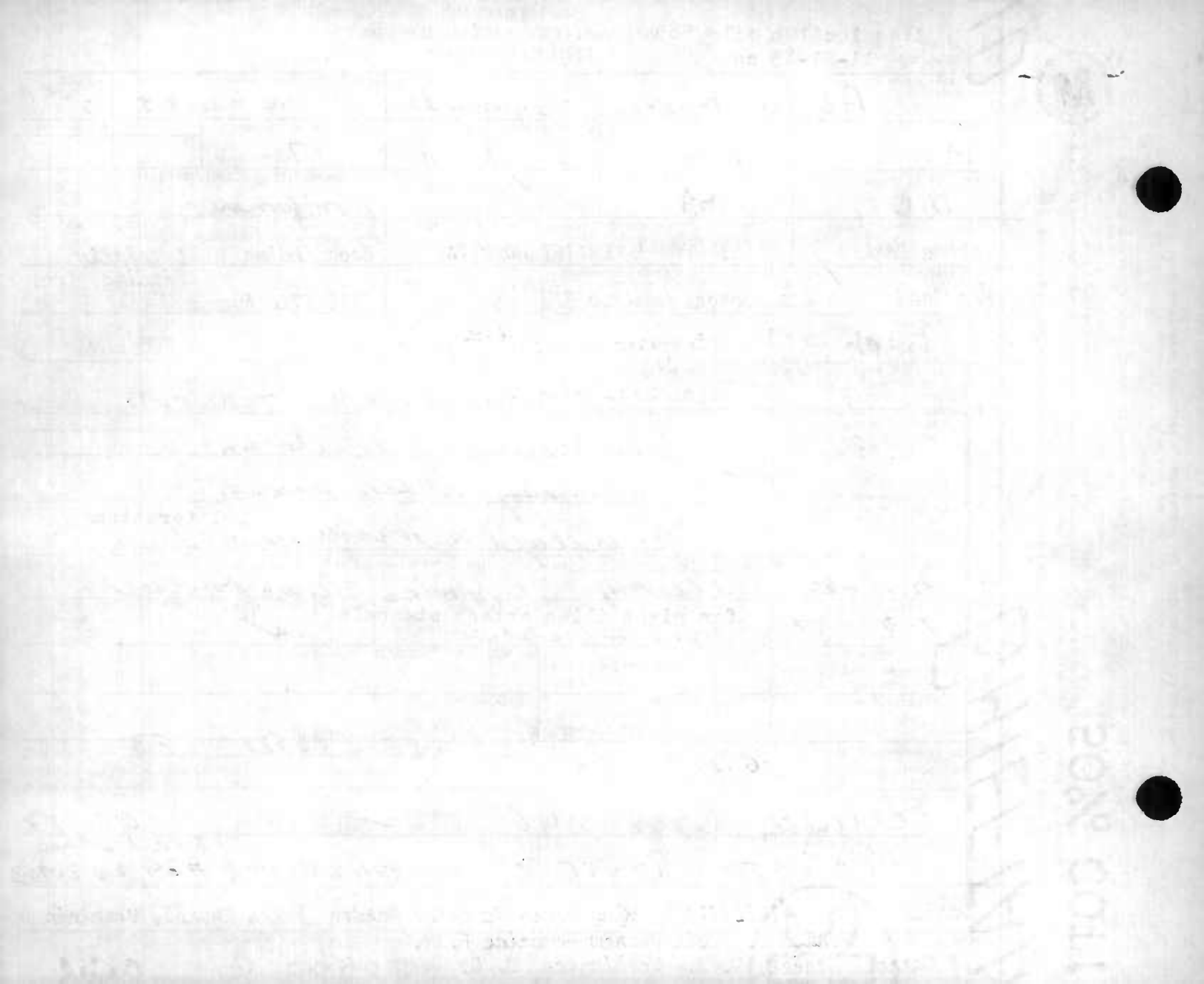
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                   |  |                                                                                                | REG. NO.                                                |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|---------------------------------------------------------|--|
| 1. FOR Item 18c&19b film 585<br>STATE REGISTRAR 11-21-83 cn                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                   |  |                                                                                                |                                                         |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ALVIN MORTON SYMONDS</b>                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  |                                                                                                | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10 - 21 - 83</b> |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>White</b>                                                                                                                           |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 7 11</b>                                            |                                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>D.C.</b>                                                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.                                              |                                                         |  |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>WASHINGTON ADVENTIST HOSPITAL</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                  |                                                         |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Book Binding</b>                                                                                                                                                                                                                                                                                                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Specialty Binding, Inc.</b>                                                                               |  |                                                                                                |                                                         |  |
| 13a. STREET ADDRESS<br><b>7312 17th Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                   |  | 13c. STREET ADDRESS<br><b>20783</b>                                                            |                                                         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Symonds</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ETHEL SPERLING</b>                                                                            |  |                                                                                                |                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br><b>577-26-4900</b>                                                                                                    |  | 17. INFORMANT<br><b>Mrs. Myra Symonds</b>                                                      |                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  | ADDRESS<br><b>Same as No. 13</b>                                                               |                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b><br><b>4149</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Coronary artery disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Generalized arteriosclerosis obliterans</b> |  |                                                                                                                                                   |  |                                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Diabetes mellitus Chronic renal failure</b>                                                                                                                                                                                                                                                                |  |                                                                                                                                                   |  |                                                                                                |                                                         |  |
| 19a. DATE OF OPERATION<br><b>8-23-83</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>For right iliac artery stenosis</b><br><b>MAJOR ANGIOPLASTY</b>                            |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |                                                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                 |                                                         |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                            |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                              |                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/22</b> , 19 <b>83</b> , to <b>10/21</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>10/21</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                        |  |                                                                                                                                                   |  |                                                                                                |                                                         |  |
| 22b. SIGNATURE<br><b>Burnett Crue MD</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  | DEGREE<br><b>MD</b>                                                                                                                               |  | 22c. DATE SIGNED<br><b>10/21/83</b>                                                            |                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KENNETH CRUZE</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 22e. ADDRESS<br><b>831 UNIVERSITY BLVD. E #29 MD 20903</b>                                                                                        |  | 22f. REGISTERAR'S SIGNATURE<br><b>SILVER SPRING</b>                                            |                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br><b>10/24/1983</b>                                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King David Memorial Garden Falls Church, Virginia</b> |                                                         |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Donald M. Stein Hebrew Memorial F. H.</b><br><b>232 Carroll Street, N. W. Washington, D. C.</b>                                                                                                                                                                                                                                                                                                        |  | DATE REC'D. BY REGISTRAR<br><b>26 1983</b>                                                                                                        |  | 25b. REGISTRAR'S SIGNATURE<br><b>Dr. J. C. Smith</b>                                           |                                                         |  |

BP 313





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                               |                                                                                                                                                             |                                                                                |                                                                                                 |                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Clara E. Talbert                                                                                                                                                                                                                                                                                                                                 |                                                                                                                               |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Oct. 7 1983                             |                                                                                                 | 2b. HOUR<br>7:00 PM                                                                                                        |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                        | 4. RACE<br>White                                                                                                              | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 31 1896                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87                                          |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br>IF UNDER 24 HRS                                                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                  |                                                                                                 |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>Wheaton                                                                                                                                                                                                                                                                                                                                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3923 Weller Road |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home                                                       |                                                                                                                            |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                                                       |                                                                                                                               | 13b. COUNTY<br>Montgomery                                                                                                                                   | 13c. CITY OR TOWN<br>Wheaton                                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>3923 Weller Road 20906                                                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Washington Slonaker                                                                                                                                                                                                                                                                                                                    |                                                                                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma Rebecca Myerly                                                                                        |                                                                                |                                                                                                 |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                              |                                                                                                                               | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----<br>217-52-6496                                                                             |                                                                                | 17. INFORMANT<br>ADDRESS<br>Gladys B. Enright Same as items 13a-e                               |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>acute cerebral vascular accident</i><br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last              |                                                                                                                               |                                                                                                                                                             |                                                                                |                                                                                                 | APPROXIMATE INTERVAL BETWEEN CAUSE AND DEATH<br>24 hrs                                                                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                                                  |                                                                                                                               |                                                                                                                                                             |                                                                                |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                |                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                                                                                 |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                       |                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                 |                                                                                                                            |
| 22a. I certify that (1) this hospital attended the deceased from <i>July</i> 19 <i>77</i> to <i>Oct 7</i> 19 <i>83</i> , that (1) <input checked="" type="radio"/> (we) last saw the deceased alive on <i>Oct 3</i> 19 <i>83</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If two) (did) (and) not view the body after death. |                                                                                                                               |                                                                                                                                                             |                                                                                |                                                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br><i>Myron L. Lenkin MD</i>                                                                                                                                                                                                                                                                                                                                             |                                                                                                                               | DEGREE                                                                                                                                                      |                                                                                | 22c. DATE SIGNED<br><i>10/7/83</i>                                                              |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Myron L. Lenkin                                                                                                                                                                                                                                                                                                                                |                                                                                                                               | 22e. ADDRESS<br>2309 Shorefield Rd. Wheaton, Md. 20902                                                                                                      |                                                                                |                                                                                                 |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                  | 23b. DATE<br>Oct. 12, 1983                                                                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br>Uniontown Ch. of God                                                                                                  |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Uniontown, Carroll, Maryland                      |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br>Skiles Funeral Home Taneytown, Md. 21787                                                                                                                                                                                                                                                                                                                |                                                                                                                               | 25. DATE REC'D. BY REGISTRAR<br>OCT 14 1983                                                                                                                 |                                                                                |                                                                                                 |                                                                                                                            |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                        |                                                                                                                                                  |                                                                                                                                                             |                                                                                      |                                                                                       |                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>SUZANNE TAPIERO</b>                                                                                                                          |                                                                                                                                                  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 8, 1983</b>                        |                                                                                       | 2b. HOUR<br><b>3:30p</b>                          |
| 3. SEX<br><b>Female</b>                                                                                                                                                                | 4. RACE<br><b>White</b>                                                                                                                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 20, 1929</b>                                                                                                  |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b> YRS.                                     | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Morocco</b>                                                                                                                            | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                         |                                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>                                                                                                                                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Hebrew Home of Greater Wash.</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |                                                                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b> |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Sil. Spg.</b> |                                                                                                                                                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |                                                                                      | 13e. STREET ADDRESS<br><b>2853 Aquarius Avenue</b>                                    |                                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>David Elmaleh</b>                                                                                                                         |                                                                                                                                                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>(unknown)</b>                                                                                           |                                                                                      |                                                                                       |                                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                      |                                                                                                                                                  | 16b. SOCIAL SECURITY NO.<br><b>579-54-9327</b>                                                                                                              |                                                                                      | 17. INFORMANT<br>ADDRESS<br><b>Md. Ralph Tapiero; 2203 Washington Ave., Sil. Spg.</b> |                                                   |

|                                                                                                                                                                          |  |                                                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1991</b> IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>18 months</b> |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                         |  |                                                                     |
| (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF                                                                                                                              |  |                                                                     |
| (c) _____                                                                                                                                                                |  |                                                                     |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**None**

|                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                        |  |                                                                                      |                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                            |
| 22a. I certify that (I) (if <del>XXXX</del> ) attended the deceased from <b>Sept. 28, 1983</b> to <b>Oct. 8, 1983</b> , that (I) <del>(X)</del> lost<br>saw the deceased alive on <b>Oct. 8, 1983</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated<br>above. (I) <del>(we)</del> <del>(did not)</del> view the body after death. |  |                                                                        |  |                                                                                      |                                                                                                                            |
| 22b. SIGNATURE<br><i>R. Bass</i>                                                                                                                                                                                                                                                                                                                                                               |  | DEGREE<br><b>M.D.</b>                                                  |  | 22c. DATE SIGNED<br><b>10-8-83</b>                                                   |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. BASS, M.D.</b>                                                                                                                                                                                                                                                                                                                                  |  | 22e. ADDRESS<br><b>3929 Ferarra Drive; Wheaton, Md.</b>                |  |                                                                                      |                                                                                                                            |

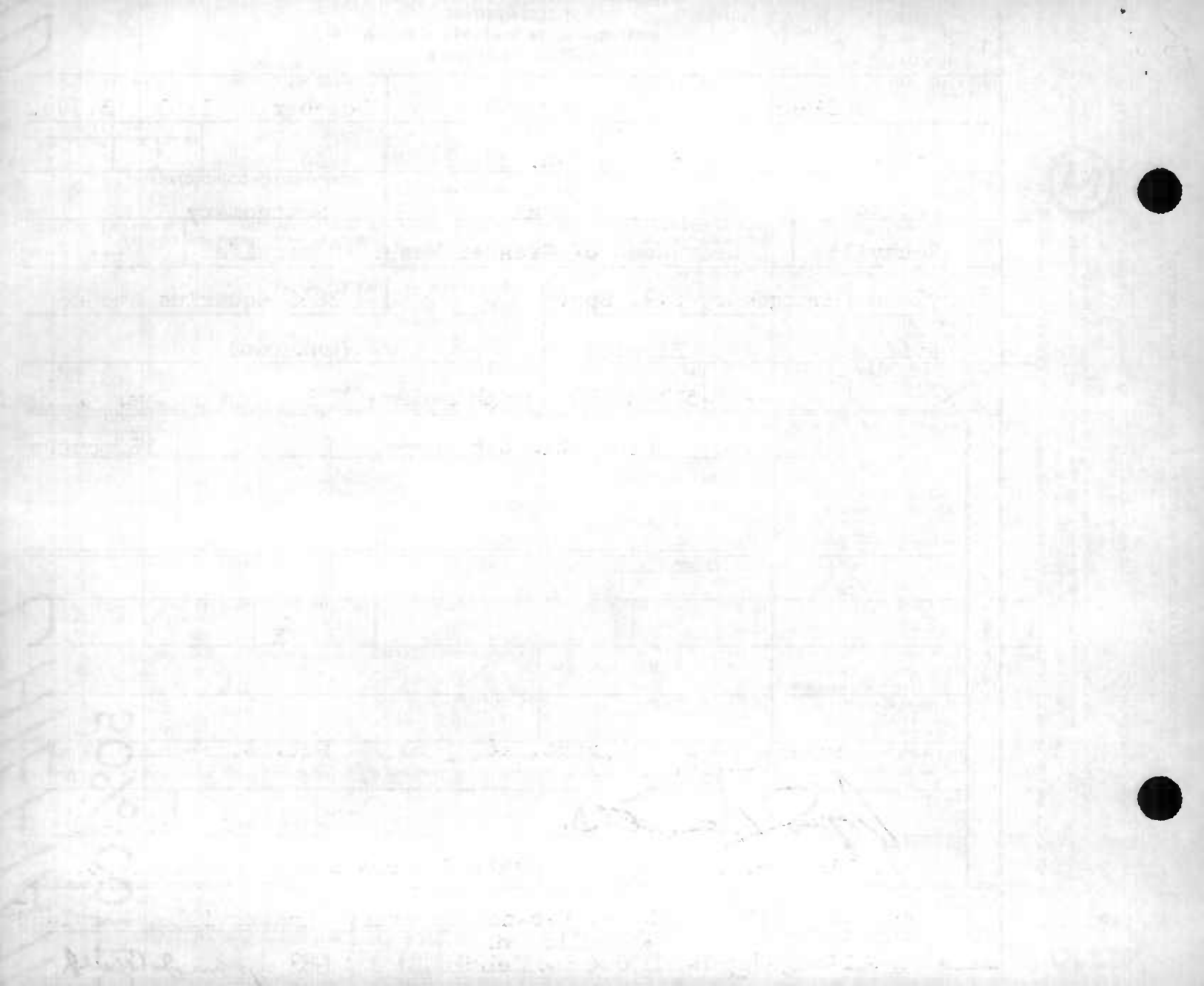
|                                                                                        |                               |                                                                   |                                                                            |
|----------------------------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------------|----------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                          | 23b. DATE<br><b>10-9-1983</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Lebanon Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hyattsville, Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b> |                               | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 13 1983</b>               | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connelley</i>                     |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                        |  |                                                                                                                             |  | REG. NO.                                                                                                                                                    |  |                                                                                                                         |                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                             |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                            |  |                                                                                                                         |                                                       |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Leonard Joseph Thebe'rge<br>Leonard JOSEPH Theberge                                                                                                                                                                                                                                                                   |  |                                                                                                                             |  | 2b. HOUR<br>7:45 AM                                                                                                                                         |  |                                                                                                                         |                                                       |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br>White                                                                                                            |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>May 17, 1935                                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>48 YRS.                                                                              |                                                       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                      |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                                                                  |                                                       |
| 10. CITY OR TOWN OF DEATH<br>Bethesda                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Attorney                                                                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Law                                                                                |                                                       |
| 13a. STATE<br>--- 20016                                                                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY<br>---                                                                                                          |  | 13c. CITY OR TOWN<br>Washington, DC                                                                                                                         |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                                       |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Lionel --- Thebe'rge                                                                                                                                                                                                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Antoinette --- Tomasulo                                                       |  | 13e. STREET ADDRESS<br>4333 Westover Place, N.W. 99999                                                                                                      |  |                                                                                                                         |                                                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br>- 1963 079-26-7066                                                                              |  | 17. INFORMANT ADDRESS<br>Virginia Rice Thebe'rge, Same address as 13.                                                                                       |  |                                                                                                                         |                                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>multiple myeloma</u><br>2030<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.             |  |                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____                                                                                                                                                                                                                                  |  |                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                                         |                                                       |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                            |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                         |                                                       |
| 21d. INJURY OCCURRED WHERE AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                         |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                         |                                                       |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/27</u> , 19 <u>83</u> , to <u>10/26/83</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>10/26/83</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                                         |                                                       |
| 22b. SIGNATURE<br>Jeremy V. Cooke                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                             |  | DEGREE<br>MD                                                                                                                                                |  | 22c. DATE SIGNED<br>10/26/83                                                                                            |                                                       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jeremy V. Cooke                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                             |  | 22e. ADDRESS<br>10400 Connecticut Ave., Kensington, Md.                                                                                                     |  |                                                                                                                         |                                                       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br>10/28/83                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven Cemetery                                                                                               |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Silver Spring, Maryland                                                      |                                                       |
| 24. FUNERAL DIRECTOR NAME<br>Joseph Gawler's Sons, Inc.                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>OCT 31 1983 [Signature]                                                                         |  |                                                                                                                         |                                                       |
| 5130 Wisconsin Ave., NW, Washington, D.C. 20016                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                                         |                                                       |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 1 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                              |  | REG. NO.                                                                                                                                                    |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                    |  | 2a. DATE OF DEATH                                                                                                                                           |  |
| FIRST MIDDLE LAST<br>ARTHUR E. EARL TICE TICE                                                                                                                                                                                                                                                                       |  | MONTH DAY YEAR<br>10/25/83                                                                                                                                  |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                      |  | 2b. HOUR<br>205 AM                                                                                                                                          |  |
| 4. RACE<br>WHITE                                                                                                                                                                                                                                                                                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>50 YRS.                                                                                                                  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JUNE, 5 1933                                                                                                                                                                                                                                                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York                                                                                                                                                                                                                                                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                                 |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                                                                                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital                                 |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Manager                                                                                                                                                                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Control Data                                                                                                           |  |
| 13a. STATE<br>Md. 20854                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY<br>MONT.                                                                                                                                        |  |
| 13c. CITY OR TOWN<br>POTOMAC                                                                                                                                                                                                                                                                                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>EARL HENRY TICE                                                                                                                                                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MADELINE NELSON                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>yes                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>1954-1958 059-28-5730                                                                                                           |  |
| 17. INFORMANT<br>Patricia G. Tice                                                                                                                                                                                                                                                                                   |  | ADDRESS<br>Same as # 13                                                                                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1739<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Metastatic Disease of the Brain, Skin<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) MALIGNANT MELANOMA.                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10                                                                                                                                                                                 |  |                                                                                                                                                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                                      |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                   |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/1/83, 19, to 10/25/83, 19-83, that (I) (we) lost saw the deceased alive on 10/24/83, 19-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |                                                                                                                                                             |  |
| 22b. SIGNATURE<br>Hamid Montakhab MD.                                                                                                                                                                                                                                                                               |  | 22c. DATE SIGNED<br>20852                                                                                                                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HAMID MONTAKHAB, MD                                                                                                                                                                                                                                                        |  | 22e. ADDRESS<br>611 Executive Blvd Rockville MD                                                                                                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>CREMATION                                                                                                                                                                                                                                                              |  | 23b. DATE<br>OCT. 25, 1983                                                                                                                                  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>LEE CREMATORY                                                                                                                                                                                                                                                                 |  | 23d. LOCATION<br>WASHINGTON, D. C.                                                                                                                          |  |
| 24. FUNERAL DIRECTOR<br>FRANCIS H. BARBER                                                                                                                                                                                                                                                                           |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 27 1983                                                                                                                |  |
| LAYTONSVILLE, MD. 20879                                                                                                                                                                                                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE<br>Francis H. Barber                                                                                                             |  |

BP

1. The first part of the report is a general statement of the purpose and scope of the study. It is followed by a brief review of the literature on the subject. The next section is a description of the methods used in the study. This is followed by a presentation of the results of the study. The final section is a discussion of the results and their implications.

The results of the study show that there is a significant difference between the two groups. This difference is most pronounced in the first part of the study. The results also show that there is a significant difference between the two groups in the second part of the study. The results of the study suggest that there is a significant difference between the two groups in the third part of the study.

The results of the study suggest that there is a significant difference between the two groups in the fourth part of the study. The results of the study suggest that there is a significant difference between the two groups in the fifth part of the study. The results of the study suggest that there is a significant difference between the two groups in the sixth part of the study.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|                                                                                                                          |  |                                                                                                                                                   |                                                                 |                                                                                                                                                             |                                                                                                                           |                                                                                                 |
|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>PAULINA NMN TITERMANIS</b>                                |  |                                                                                                                                                   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10-6-83</b>           |                                                                                                                                                             | 2b. HOUR<br><b>3:50</b> M                                                                                                 |                                                                                                 |
| 3. SEX<br><b>Female</b>                                                                                                  |  | 4. RACE<br><b>white</b>                                                                                                                           |                                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 13 1892</b>                                                                                                    |                                                                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS.                                               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Latvia</b>                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Latvia</b>                                                                                                     |                                                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hospital</b> |                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>House-keeper</b>                                                                     |                                                                                                                           | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>Maryland</b> |  |                                                                                                                                                   | 13b. COUNTY<br><b>Montgomery</b>                                |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Takoma Park</b>                                                                                   |                                                                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>                                                                 |  |                                                                                                                                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b> |                                                                                                                                                             |                                                                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                        |  |                                                                                                                                                   | 16b. SOCIAL SECURITY NO.<br><b>220-34-4363</b>                  |                                                                                                                                                             | 17. INFORMANT<br><b>Friend</b><br><b>Regita Novikova</b><br>ADDRESS<br><b>1624 Oaklawn Court Silver Spring, Md. 20903</b> |                                                                                                 |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **respiratory-cardiac arrest in sleep**

**2059**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Paroxysmal atrial fibrillation with myocardial**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Chronic atrial fibrillation**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
**2-4 weeks**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                               |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8.12. 1983</b> , to <b>10.6. 1983</b> , that (I) (we) lost<br>saw the deceased alive on <b>10.5. 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Frederic W. Brennwald</b> M.D.<br>22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>F.W. BRENNWALD</b>                                                                                                                                                                                                                         |  |                                                                        |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10.6.83</b>                                                                                         |  |
| 22e. ADDRESS<br><b>831 University Blvd E. Silver Spring</b>                                                                                                                                                                                                                                                                                   |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                            |  |

|                                                                                                                      |  |                                   |  |                                                                  |  |                                                                       |  |
|----------------------------------------------------------------------------------------------------------------------|--|-----------------------------------|--|------------------------------------------------------------------|--|-----------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>                                                                     |  | 23b. DATE<br><b>Oct. 10, 1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, D.C.</b> |  |
| 24. FUNERAL DIRECTOR <b>Francis J. Collins</b><br>NAME ADDRESS<br><b>500 University Blvd., W. Silver Spring, Md.</b> |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 13 1983</b>              |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Smith</b>                    |  |

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Handwritten notes and a table. The table has several columns and rows, with some cells containing 'X' marks. The text is mostly illegible due to fading.

Handwritten notes and a table. The table has several columns and rows, with some cells containing 'X' marks. The text is mostly illegible due to fading.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                          |                                                                                                                                                             |                                                                                             | REG. NO.                                                                                                                                             |                                                  |                                                                                                                                       |       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-------|
| 1. DECEASED NAME (TYPE OR PRINT)<br>PHYLLIS ANN TIMMINS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                          |                                                                                                                                                             |                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>OCTOBER 11 1983                                                                                                  |                                                  | 2b. HOUR<br>1:00 <sup>a</sup> <sub>m</sub>                                                                                            |       |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br>CAUCASIAN                                                                                                     | 5. DATE OF BIRTH MONTH DAY YEAR<br>NOVEMBER 9 1932                                                                                                          |                                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>50 YRS.                                                                                                           |                                                  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                             |       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>SOUTH DAKOTA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 7b. CITIZEN OF WHAT COUNTRY?<br>UNITED STATES                                                                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                                                                                               |                                                  |                                                                                                                                       |       |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NAVAL HOSPITAL |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RECEPTIONIST               |                                                                                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beauty Shop |                                                                                                                                       |       |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                          | 13b. CITY OR TOWN<br>PRINCE GEORGE'S FT. WASHINGTON                                                                                                         | 13c. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS<br>10012 MIKE ROAD                                                                                                               |                                                  |                                                                                                                                       | 20744 |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>EDWIN SAUKKO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                          | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ALMA MARIE KOPECKI                                                                                            |                                                                                             | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO                                                                                 |                                                  |                                                                                                                                       |       |
| 16b. SOCIAL SECURITY NO.<br>525-62-3173                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                          | 17. INFORMANT ADDRESS<br>ALMA EASTON, 10012 MIKE ROAD, FT. WASHINGTON, MD 20744                                                                             |                                                                                             |                                                                                                                                                      |                                                  |                                                                                                                                       |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>4275<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                   |                                                                                                                          |                                                                                                                                                             |                                                                                             |                                                                                                                                                      |                                                  |                                                                                                                                       |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                          |                                                                                                                                                             |                                                                                             |                                                                                                                                                      |                                                  |                                                                                                                                       |       |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                             | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                 |                                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                          | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                     |                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                  |                                                                                                                                       |       |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                          | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                         |                                                                                             | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                       |                                                  |                                                                                                                                       |       |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>AUGUST 29</u> , 19 <u>83</u> , to <u>OCTOBER 11</u> , 19 <u>83</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>OCTOBER 11</u> , 19 <u>83</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death. |                                                                                                                          |                                                                                                                                                             |                                                                                             |                                                                                                                                                      |                                                  |                                                                                                                                       |       |
| 22b. SIGNATURE<br><i>James B. Hirschhorn</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                          |                                                                                                                                                             |                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                  | 22c. DATE SIGNED<br>12 OCT 83                                                                                                         |       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. B. HIRSCHHORN, LT, MC, USNR                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                          |                                                                                                                                                             |                                                                                             | 22e. ADDRESS<br>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814                                                   |                                                  |                                                                                                                                       |       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                          | 23b. DATE<br>10/14/83                                                                                                                                       |                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National Cem.                                                                                        |                                                  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Ft. Myer Virginia                                                                          |       |
| 24. FUNERAL DIRECTOR NAME<br>George P. Kalas Funeral Home Oxon Hill, Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                          |                                                                                                                                                             |                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>OCT 17 1983                                                                                                         |                                                  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Conner</i>                                                                                   |       |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 is marked, any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                            |                       |                                                                                                                                                             |                                                                                                 |                                                                                   |                                                 |                                                                                                                                            |                                   | REG. NO. 27881                                                                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                            |                       |                                                                                                                                                             |                                                                                                 |                                                                                   |                                                 |                                                                                                                                            |                                   |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>GUY HARRISON TOBEY                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                            |                       |                                                                                                                                                             | 2a. DATE OF DEATH<br>10 16 83                                                                   |                                                                                   |                                                 |                                                                                                                                            | 2b. HOUR<br>5 <sup>30</sup> P. M. |                                                                                                                            |  |
| 1. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br>WHITE                                                                                                                           |                       | 5. DATE OF BIRTH<br>JANUARY 1, 1914                                                                                                                         |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69                                             |                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                          |                                   | 8. IF UNDER 24 HRS<br>HOURS MIN.                                                                                           |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MASSACHUSETTS                                                                                                                                                                                                                                                                                                                                                                      |  | 7c. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                     |                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                            |                                                 |                                                                                                                                            |                                   |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>TAKOMA PARK                                                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>WASHINGTON ADVENTIST HOSPITAL |                       |                                                                                                                                                             |                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SELF EMPLOYED |                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>LUMBER CO.                                                                                            |                                   |                                                                                                                            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY PRINCE GEORGES 13c. CITY OR TOWN BELTSVILLE                                                                                                                                                                                                                                                     |  |                                                                                                                                            |                       |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                   | 13e. STREET ADDRESS<br>4906 WICOMICO AVE. 20705 |                                                                                                                                            |                                   |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>FRED C. TOBEY                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                            |                       |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SUSAN L. CILBY                                 |                                                                                   |                                                 |                                                                                                                                            |                                   |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>001-01-4131                                                                     |                       | 17. INFORMANT ADDRESS<br>NEW HAMPSHIRE 03225<br>FRITZ TOBEY, SON, P.O. BOX 74, CENTER BARNSTEAD                                                             |                                                                                                 |                                                                                   |                                                 |                                                                                                                                            |                                   |                                                                                                                            |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>1539 IMMEDIATE CAUSE (a) Cardiorespiratory arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Carcinomatosis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(c) Colon carcinoma<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                            |                       |                                                                                                                                                             |                                                                                                 |                                                                                   |                                                 |                                                                                                                                            |                                   |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                                                            |  |                                                                                                                                            |                       |                                                                                                                                                             |                                                                                                 |                                                                                   |                                                 |                                                                                                                                            |                                   |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                            |                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 |                                                                                   |                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                        |  |                                                                                                                                            |                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |                                                 |                                                                                                                                            |                                   |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                  |  |                                                                                                                                            |                       | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |                                                 |                                                                                                                                            |                                   |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/11, 1983, to 10/16, 1983, that (I) (we) lost<br>saw the deceased above 10/16, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                                                                                                           |  |                                                                                                                                            |                       |                                                                                                                                                             |                                                                                                 |                                                                                   |                                                 |                                                                                                                                            |                                   |                                                                                                                            |  |
| 22b. SIGNATURE<br>TJ ORELLANO                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                            |                       | DEGREE<br>MD                                                                                                                                                |                                                                                                 |                                                                                   |                                                 | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                   | 22c. DATE SIGNED<br>10/16/83                                                                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>TRISTAN J. ORELLANO                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                            |                       | 22e. ADDRESS<br>14201 Laurel Park Dr Laurel Md 20707                                                                                                        |                                                                                                 |                                                                                   |                                                 |                                                                                                                                            |                                   |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>CREMATION                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                            | 23b. DATE<br>10/18/83 |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>CEDAR HILL CREMATORY                                      |                                                                                   |                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SUTTLAND PG. MD.                                                                             |                                   |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME RICHARD RAPP, INC. ADDRESS 1120 CONN. AVE., N.W. #940, WASH. D.C. 20036                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                            |                       |                                                                                                                                                             |                                                                                                 |                                                                                   |                                                 |                                                                                                                                            |                                   |                                                                                                                            |  |
| 25. DATE RECORDED BY REGISTRAR<br>OCT 20 1983                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                            |                       |                                                                                                                                                             |                                                                                                 |                                                                                   |                                                 |                                                                                                                                            |                                   |                                                                                                                            |  |

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100% COTTON

WASH STATE

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1231  
WASHINGTON  
STATE  
UNIVERSITY  
LIBRARY  
SPRINGFIELD  
ILLINOIS  
661-10-1000  
100% COTTON  
WASH STATE  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------|------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR                          |      |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        | MONTH DAY YEAR                                                                                                                                           |                                                                     | MONTH DAY YEAR                    |      |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                        | 10 27 83                                                                                                                                                 |                                                                     | 9:50 AM                           |      |
| Archie G. Tolbert                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                    | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR                   |      |
| Male                                                                                                                                                                                                                                                                                                                                                                                      | White                                                                                                  | MONTH DAY YEAR                                                                                                                                           | 62 YRS.                                                             | MONTHS                            | DAYS |
|                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        | 4 16 21                                                                                                                                                  |                                                                     |                                   |      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                 | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                   |      |
| Va.                                                                                                                                                                                                                                                                                                                                                                                       | U.S.A.                                                                                                 |                                                                                                                                                          | Montgomery MD.                                                      |                                   |      |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       | 12b. KIND OF BUSINESS OR INDUSTRY |      |
| Rockville                                                                                                                                                                                                                                                                                                                                                                                 | 204 Reading Terrace                                                                                    |                                                                                                                                                          | Install. Glass                                                      | Glass Co.                         |      |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                | 13b. COUNTY                                                                                            | 13c. CITY OR TOWN                                                                                                                                        | 13d. INSIDE CITY LIMITS?                                            | 13e. STREET ADDRESS               |      |
| Md.                                                                                                                                                                                                                                                                                                                                                                                       | Montgomery                                                                                             | Rockville                                                                                                                                                | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 204 Reading Terrace (20850)       |      |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                         | 15. MOTHER'S MAIDEN NAME                                                                               |                                                                                                                                                          | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |                                   |      |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                         | FIRST MIDDLE LAST                                                                                      |                                                                                                                                                          | 16b. SOCIAL SECURITY NO.                                            |                                   |      |
| Edward - Tolbert                                                                                                                                                                                                                                                                                                                                                                          | Iowa - Mabrey                                                                                          |                                                                                                                                                          | 227-16-1002                                                         |                                   |      |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                                                                                             | 104 Hutton St. Gaithersburg, Md. 20877                                                                 |                                                                                                                                                          |                                                                     |                                   |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Small Cell (not cell) Lung Cancer</u>                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastasis to lymph nodes, bone, etc.</u>                                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>after low dose lung, Pancreatic</u>                                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK                                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Mar</u> 19 <u>83</u> , to <u>27 Oct</u> 19 <u>83</u> , that (I <del>was</del> ) last saw the deceased alive on <u>26 Oct</u> 19 <u>83</u> , and that in (my <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above. (I <del>was</del> ) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 22b. SIGNATURE DEGREE                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 22c. DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 22e. ADDRESS                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| DONALD E DILLON, M.D.                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 1811 Prince Philip Drive Olney, Md. 20832                                                                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 23b. DATE                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 23e. DATE REC'D. BY REGISTRAR                                                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 23f. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |
| Gartner Sandison F.H. Gaithersburg, Md. 20877                                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                                     |                                   |      |

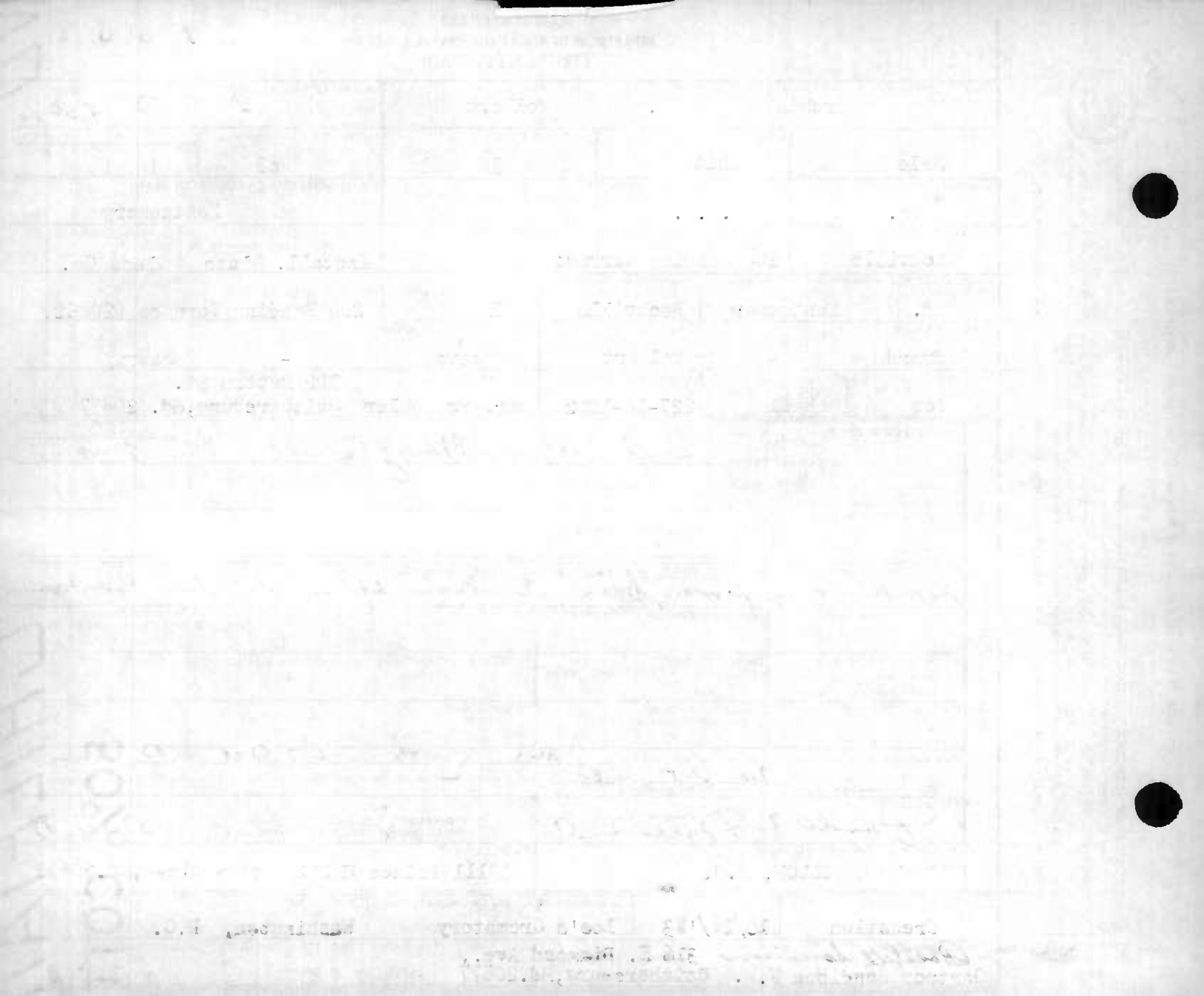
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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                                         |                                                                                                              |                                            |                                                                                                                                       |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|--------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Elizabeth C. Tolson</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                 | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 29, 1983</b>         |                                                                                                                                                             |                                                                                         | 2b. HOUR<br><b>11:00pm</b>                                                                                   |                                            |                                                                                                                                       |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br><b>White</b>                                                                                                                         |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 1, 1907</b>                                                                                                   |                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76 77</b>                                                              |                                            | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>                                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Janet, Penn.</b>                                                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                   |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                                |                                            |                                                                                                                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |                                                                        |                                                                                                                                                             |                                                                                         | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Business Mgr. Landscaping</b> |                                            |                                                                                                                                       |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY<br><b>Montgomery</b>                                                                                                                |                                                                        | 13c. CITY OR TOWN<br><b>Silver Spring</b>                                                                                                                   |                                                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>              |                                            | 13e. STREET ADDRESS<br><b>3403 Hallaton Court 20906</b>                                                                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Copeland</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Clark</b>     |                                                                                                                                                             |                                                                                         |                                                                                                              |                                            |                                                                                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                 | 16b. SOCIAL SECURITY NO.<br><b>216-12-4497</b>                         |                                                                                                                                                             |                                                                                         | 17. INFORMANT ADDRESS<br><b>Daniel C. Tolson same as 13e</b>                                                 |                                            |                                                                                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>intracerebral hemorrhage</b><br><b>4310</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>arteriosclerotic cerebrovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1 day</b> |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                                         |                                                                                                              |                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a:<br><b>Breast carcinoma</b>                                                                                                                                                                                                                                                                  |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                                         |                                                                                                              |                                            |                                                                                                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                         | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                        |  |                                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                               |                                            |                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                            |                                            |                                                                                                                                       |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>10/29</b> , 19 <b>83</b> , to <b>10/29</b> , 19 <b>83</b> , that (we) lost saw the deceased alive on <b>10/29</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.                                                                |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                                         |                                                                                                              |                                            |                                                                                                                                       |  |
| 22b. SIGNATURE<br><b>Edward P. Taubman</b> MD<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                                                                                                                                                                                                                     |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                                         | 22c. DATE SIGNED<br><b>10/31/83</b>                                                                          |                                            |                                                                                                                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Edward P. Taubman</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                                         | 22e. ADDRESS<br><b>18111 Prince Philip Dr. Olney, Md</b>                                                     |                                            |                                                                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                 | 23b. DATE<br><b>11/2/83</b>                                            |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Memorial Park Rockville, Maryland</b> |                                                                                                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |                                                                                                                                       |  |
| 24. FUNERAL DIRECTOR<br><b>Tyson Wheeler Funeral Home, Inc.</b><br><b>1331 Rockville Pike Rockville, Md. 20852</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                                         | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 4 1983</b>                                                           |                                            | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                                                                                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                          |  |                                                                                                                                              |                                                                            |                                                                                                                                                             |                                                                    |                                                                                          |                                                                                                 |                                                                 |                                                                       |  |
|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LORRAINE E. TOREK</b>                                                          |  |                                                                                                                                              | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 26, 1983</b>             |                                                                                                                                                             |                                                                    | 2b. HOUR<br><b>2:30 PM</b>                                                               |                                                                                                 |                                                                 |                                                                       |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                  |  | 4. RACE<br><b>WHITE</b>                                                                                                                      |                                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>SEPTEMBER 25, 1934</b>                                                                                             |                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b> YRS                                         |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |                                                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                |                                                                            | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                            |                                                                                                 |                                                                 |                                                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>GAITHERSBURG</b>                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>10500 SENECA RIDGE DRIVE</b> |                                                                            |                                                                                                                                                             |                                                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SELF EMPLOYED</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>ATTORNEY</b>            |                                                                       |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b> |  |                                                                                                                                              | 13b. COUNTY<br><b>MONTGOMERY</b>                                           |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>GAITHERSBURG</b>                           |                                                                                          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                 | 13e. STREET ADDRESS / ZIP CODE<br><b>10500 SENECA RIDGE DR. 20879</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES N. ENGLISH</b>                                                        |  |                                                                                                                                              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CHARLOTTE ROSE HOF</b> |                                                                                                                                                             |                                                                    |                                                                                          |                                                                                                 |                                                                 |                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                        |  |                                                                                                                                              | 16b. SOCIAL SECURITY NO.<br><b>117-26-4595</b>                             |                                                                                                                                                             | 17. INFORMANT<br><b>MARIA A. VACCHIO, SILVER SPRING, MD. 20910</b> |                                                                                          |                                                                                                 |                                                                 |                                                                       |  |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Adenocarcinoma of Lung with Brain Metastases</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b> |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:

|                                                                                                                                                                                                                                                                                                                                                        |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                             |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/9</b> , 19 <b>82</b> , to <b>10/26</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>9/19/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Israel Spector MD</b>                                                                                                                                                                                                                                                                                                             |  | DEGREE                                                                 |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10/26/83</b>                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Israel Spector MD</b>                                                                                                                                                                                                                                                                                      |  | 22e. ADDRESS<br><b>12001 Ferrara Ave Wheaton Md 20906</b>              |  |                                                                                                                                            |  |                                                                                                                            |  |

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| 23a. BURIAL, CREMATION, REMOVAL (CHECK)<br><b>CREMATION</b> |  | 23b. DATE<br><b>10/27/83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL CREMATORY</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SUITLAND PG. MD.</b> |  |
|-------------------------------------------------------------|--|------------------------------|--|-------------------------------------------------------------------|--|-----------------------------------------------------------------------|--|

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|-----------------------------------------------------------|--|---------------------------------------------------------------|--|------------------------------------------------|--|------------------------------------------------|--|
| 24. FUNERAL DIRECTOR<br>NAME<br><b>RICHARD RAPP, INC.</b> |  | ADDRESS<br><b>1120 CONN. AVE., N.W. #940 WASH. D.C. 20036</b> |  | DATE REC'D. BY REGISTRAR<br><b>OCT 31 1983</b> |  | REGISTRAR'S SIGNATURE<br><b>John J. Calver</b> |  |
|-----------------------------------------------------------|--|---------------------------------------------------------------|--|------------------------------------------------|--|------------------------------------------------|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                |  | REG. NO.                                                                                               |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                                             |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                      |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                   |  | LAST                                                                                         |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                        |  | 2b. HOUR                                                    |  |
| Margaret L. Trail                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  | 10 18 83                                                                                                                |  | 5 18 A.M.                                                   |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                              |  | IF UNDER 1 YEAR MONTHS DAYS                                                                                             |  | IF UNDER 24 HRS. HOURS MIN.                                 |  |
| Female                                                                                                                                                                                                                                                                                                                                                                                |  | White                                                                                                  |  | March 1, 1907                                                                                                                                            |  | 76                                                                                           |  |                                                                                                                         |  |                                                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                         |  |                                                                                                                         |  |                                                             |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                              |  | U. S. A.                                                                                               |  |                                                                                                                                                          |  | Montgomery MD.                                                                               |  |                                                                                                                         |  |                                                             |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                          |  |                                                                                              |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY                           |  |
| Bethesda                                                                                                                                                                                                                                                                                                                                                                              |  | Suburban Hospital                                                                                      |  |                                                                                                                                                          |  |                                                                                              |  | Housewife                                                                                                               |  | Home                                                        |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS                                                                                                     |  |                                                             |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                              |  | Montgomery                                                                                             |  | Rockville                                                                                                                                                |  |                                                                                              |  | 634 Lincoln Street 20850                                                                                                |  |                                                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                             |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                                             |  |
| Millard E. Peake                                                                                                                                                                                                                                                                                                                                                                      |  | Margaret A. Tucker                                                                                     |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.                                                                               |  | 17. INFORMANT ADDRESS                                                                                                                                    |  |                                                                                              |  |                                                                                                                         |  |                                                             |  |
| no                                                                                                                                                                                                                                                                                                                                                                                    |  | 218-20-2402                                                                                            |  | Raymond B. Trail 332 Broadwood Dr. Rockville, Maryland 20851                                                                                             |  |                                                                                              |  |                                                                                                                         |  |                                                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Disease of kidney metastatic to liver</u> 1890 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>pleural effusion</u>                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |                                                                                                                                                          |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |  |                                                                                              |  |                                                                                                                         |  |                                                             |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                              |  |                                                                                                                         |  |                                                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/12/83</u> 19 <u>83</u> , to <u>10/18/83</u> 19 <u>83</u> , that (I) <del>lost</del> saw the deceased alive on <u>10/17/83</u> 19 <u>83</u> , and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did not</del> view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                                             |  |
| 22a. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                        |  | DEGREE                                                                                                 |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED                                                                             |  |                                                                                                                         |  |                                                             |  |
| Robert C. Macon                                                                                                                                                                                                                                                                                                                                                                       |  | M.D.                                                                                                   |  |                                                                                                                                                          |  | 10/18/83                                                                                     |  |                                                                                                                         |  |                                                             |  |
| 22a. DEATH'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                     |  | 22b. ADDRESS                                                                                           |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                                             |  |
| Robert C. Macon                                                                                                                                                                                                                                                                                                                                                                       |  | 809 Viers Mill Road, Rockville, Md.                                                                    |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION                                                                                |  |                                                                                                                         |  |                                                             |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                |  | 10/21/83                                                                                               |  | St. Mary's Cemetery                                                                                                                                      |  | Rockville, Maryland STATE                                                                    |  |                                                                                                                         |  |                                                             |  |
| 24. FUNERAL HOME OR OTHER INSTITUTION (NAME AND ADDRESS)                                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR                                                                |  |                                                                                                                         |  |                                                             |  |
| Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland 20852                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          |  | OCT 24 1983                                                                                  |  |                                                                                                                         |  |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                          |  | REGISTRAR'S SIGNATURE <u>John J. Conner</u>                                                  |  |                                                                                                                         |  |                                                             |  |

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TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
DATE: [illegible]  
[illegible text block]

[illegible text block]



10/11/98  
[illegible text block]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of date.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                             |  | REG. NO.                                                                                                                                             |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>JANE W. TROY                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                             |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 03 83                                                                                                         |  |                                                                                                                            |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                             |  | 2b. HOUR<br>11 52 AM                                                                                                                                 |  |                                                                                                                            |  |
| 4. RACE<br>Caucasian                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>July 31 1923                                                                             |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>60 YRS.                                                                                                         |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, D.C.                                                                                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                                                                                               |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>C & P Telephone                                                                       |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY<br>Montgomery                                                                                                   |  | 13c. CITY OR TOWN<br>Bethesda                                                                                                                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Joseph Wells                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Helen Latterner                                                               |  | 13e. STREET ADDRESS<br>7907 Kentbury Drive 20814                                                                                                     |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br>579-26-1478                                                                                     |  | 17. INFORMANT<br>son                                                                                                                                 |  | ADDRESS<br>445 Kingwood Road Linthicum, Maryland                                                                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Failure</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Pulmonary Infarct.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Cancerous lung.</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Phlebitis - L. leg.</u> |  |                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                         |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                            |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                       |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                         |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                       |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sep. 3 1983</u> to <u>Oct 3 1983</u> , that (I) (we) last saw the deceased alive on <u>Oct 3 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                                                                                                                                           |  |                                                                                                                             |  |                                                                                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>Robert T. Thibadeau                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                             |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>10-3-83                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROBERT T. THIBADEAU                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                             |  | 22e. ADDRESS<br>Rockville Ind 20852                                                                                                                  |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br>Oct. 1983                                                                                                      |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crematory                                                                                         |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Alexandria Virginia                                                             |  |
| 24. FUNERAL DIRECTOR NAME<br>Francis J. Collins                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 6 1983                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner                                                                               |  |
| 500 University Blvd., W. Silver Spring, Md.                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                             |  |                                                                                                                                                      |  |                                                                                                                            |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                               |  |                                                                                                                                                     |  |                                                                                                                                                          |                                                                                              |                                                                                     |                                             |                                                                                                                         |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                     |  |                                                                                                                                                          | REG. NO.                                                                                     |                                                                                     |                                             |                                                                                                                         |                                              |
| 1. DECEASED NAME (TYPE OR PRINT) <b>CURTIS Lee TURNER</b>                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                     |  |                                                                                                                                                          | 2a. DATE OF DEATH                                                                            |                                                                                     | MONTH <b>10</b> DAY <b>8</b> YEAR <b>83</b> |                                                                                                                         | 2b. HOUR <b>10:07 AM</b>                     |
| 3. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE <b>Caucasian</b>                                                                                                                            |  | 5. DATE OF BIRTH <b>Dec. 12, 1913</b>                                                                                                                    |                                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b>                                           |                                             | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                                                              |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>                                                                                                   |  | 8. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED |                                                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>                  |                                             |                                                                                                                         |                                              |
| 10. CITY OR TOWN OF DEATH <b>Chevy Chase</b>                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Chevy Chase Ret. &amp; Nursing Center</b> |  |                                                                                                                                                          |                                                                                              | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Field Engineer</b> |                                             | 12b. KIND OF BUSINESS OR INDUSTRY <b>IBM</b>                                                                            |                                              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                       |  |                                                                                                                                                     |  |                                                                                                                                                          | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                     |                                             |                                                                                                                         |                                              |
| 13a. STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                         |  | 13a. COUNTY <b>Montgomery</b>                                                                                                                       |  | 13a. CITY OR TOWN <b>Rockville</b>                                                                                                                       |                                                                                              | 13b. STREET ADDRESS <b>649 Azalea Drive 20850</b>                                   |                                             |                                                                                                                         |                                              |
| 14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Turner</b> LAST <b>Turner</b>                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                     |  |                                                                                                                                                          | 15. MOTHER'S MAIDEN NAME FIRST <b>Sarah</b> MIDDLE <b>Kelly</b> LAST <b>Kelly</b>            |                                                                                     |                                             |                                                                                                                         |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO. <b>577 09 2462</b>                                                                                                         |  | 17. INFORMANT <b>Wife</b> ADDRESS <b>Jean A. Turner Same as item 13</b>                                                                                  |                                                                                              |                                                                                     |                                             |                                                                                                                         |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b>                                                                                                                                                                                                           |  |                                                                                                                                                     |  |                                                                                                                                                          |                                                                                              |                                                                                     |                                             |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>METASTATIC OAT CELL CARCINOMA-LUNG</b>                                                                                                                                                                                                                       |  |                                                                                                                                                     |  |                                                                                                                                                          |                                                                                              |                                                                                     |                                             |                                                                                                                         |                                              |
| (c) <b>N/A</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                     |  |                                                                                                                                                          |                                                                                              |                                                                                     |                                             |                                                                                                                         |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NONE</b>                                                                                                                                                                                                                       |  |                                                                                                                                                     |  |                                                                                                                                                          |                                                                                              |                                                                                     |                                             |                                                                                                                         |                                              |
| 19a. DATE OF OPERATION <b>NONE</b>                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>                                                                                         |  |                                                                                                                                                          |                                                                                              | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>                                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |                                                                                              |                                                                                     |                                             |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                 |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                              |                                                                                     |                                             |                                                                                                                         |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/31</b> , 19 <b>83</b> , to <b>10/8</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>10/8</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                     |  |                                                                                                                                                          |                                                                                              |                                                                                     |                                             |                                                                                                                         |                                              |
| 22b. SIGNATURE <b>CARE MARGOLIS</b>                                                                                                                                                                                                                                                                                                                                |  | DEGREE <b>M.O.</b>                                                                                                                                  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |                                                                                              | 22c. DATE SIGNED <b>10/8/83</b>                                                     |                                             |                                                                                                                         |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CARE MARGOLIS</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                     |  | 22e. ADDRESS <b>11404 OLD GEORGETOWN RD., ROCKVILLE, MD.</b>                                                                                             |                                                                                              |                                                                                     |                                             |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>                                                                                                                                                                                                                                                                                                         |  | 23b. DATE <b>OCT. 10, 1983</b>                                                                                                                      |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>                                                                                         |                                                                                              | 23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>Alexandria, Virginia</b>               |                                             |                                                                                                                         |                                              |
| 24. FUNERAL DIRECTOR NAME <b>ROBERT A. PUMPHREY P.A., ROCKVILLE, MARYLAND</b>                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                     |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 13 1983</b>                                                                                                         |                                                                                              | 25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>                                    |                                             |                                                                                                                         |                                              |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                              |  | 2a. DATE OF DEATH                                                                                                                                                                                                                                                                                                               |  | MONTH DAY YEAR                                                                                                                                              |  | 2b. HOUR                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                       |  | FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                               |  | FANNIE TUROFF                                                                                                                                               |  | Oct. 4, 1983 10:57P.                                                |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                    |  | 4. RACE                                                                                                                                                                                                                                                                                                                         |  | 5. DATE OF BIRTH                                                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Female                                                                                                                                                                                                                                                                                                                    |  | White                                                                                                                                                                                                                                                                                                                           |  | Feb. 6, 1890                                                                                                                                                |  | 93 YRS.                                                             |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Russia                                                                                                                                                                                                                                                                                                                    |  | USA                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                             |  | Montgomery MD.                                                      |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                                                                                                                                                                                                       |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Rockville                                                                                                                                                                                                                                                                                                                 |  | Hebrew Home of Greater Wash.                                                                                                                                                                                                                                                                                                    |  | Tailor                                                                                                                                                      |  | Dry Cleaning                                                        |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                              |  | 13b. COUNTY                                                                                                                                                                                                                                                                                                                     |  | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?                                            |  |
| Maryland                                                                                                                                                                                                                                                                                                                  |  | Montg.                                                                                                                                                                                                                                                                                                                          |  | Rockville                                                                                                                                                   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                        |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                        |  | 16b. SOCIAL SECURITY NO.                                            |  |
| Getzell                                                                                                                                                                                                                                                                                                                   |  | Jarcho                                                                                                                                                                                                                                                                                                                          |  | Fannie Jarcho                                                                                                                                               |  | No                                                                  |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                             |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                            |  | 10 yrs.                                                             |  |
| Paul Tanen; Nephew; 37 Milburn Lane                                                                                                                                                                                                                                                                                       |  | Cardiac Arrest                                                                                                                                                                                                                                                                                                                  |  | acute                                                                                                                                                       |  | 10 yrs.                                                             |  |
| Breast Cancer                                                                                                                                                                                                                                                                                                             |  | Atherosclerotic Cardiocascular Dis                                                                                                                                                                                                                                                                                              |  | 20 yrs.                                                                                                                                                     |  |                                                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                        |  | Breast Cancer                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                             |  |                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                |  | 20a. AUTOPSY?                                                                                                                                               |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                 |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                    |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                                                                                                                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)                                                                              |  |                                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                          |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19 80, to 10/4, 19 83, that (I) (we) lost<br>saw the deceased alive on 10/4, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>Peter B. Sherer, M.D.                                                                                                                                                                                                                                                                                         |  | 22c. DATE SIGNED<br>10-5-83                                                                                                                                 |  |                                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                     |  | 22e. ADDRESS                                                                                                                                                                                                                                                                                                                    |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                |  | 23b. DATE                                                           |  |
| PETER B. SHERER, M.D.                                                                                                                                                                                                                                                                                                     |  | 3947 Ferrara Drive; Wheaton, Md.                                                                                                                                                                                                                                                                                                |  | Burial                                                                                                                                                      |  | 10-7-1983                                                           |  |
| 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                                                                                                                                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                      |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR                                       |  |
| Nat'l. Cap. Heb. Cem.                                                                                                                                                                                                                                                                                                     |  | Capital Heights, Md.                                                                                                                                                                                                                                                                                                            |  | Danzansky-Goldberg Chapels; 1170 Rockville Pike                                                                                                             |  | 7 1983                                                              |  |
| 25b. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                |  | 25c. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                     |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                         |                                                                                                           |                          |                                                                                                                                                             |                   |                                                                  |                                                                                                 |                                   |  |
|-----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------|--|
| DECEASED NAME<br>(TYPE OR PRINT)                                                        |                                                                                                           | FIRST                    | MIDDLE                                                                                                                                                      | LAST              | 2a. DATE OF DEATH<br>MONTH DAY YEAR                              |                                                                                                 | 2b. HOUR<br>11 <sup>25</sup> AM   |  |
| Gertrude                                                                                |                                                                                                           |                          |                                                                                                                                                             | Uhlmann           | October 13, 1983                                                 |                                                                                                 |                                   |  |
| 3. SEX                                                                                  | 4. RACE                                                                                                   |                          | 5. DATE OF BIRTH                                                                                                                                            |                   | 6. AGE (IN YEARS LAST BIRTHDAY)                                  |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS    |  |
| Female                                                                                  | White                                                                                                     |                          | June 11, 1896                                                                                                                                               |                   | 87 YRS.                                                          |                                                                                                 |                                   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                                            | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |                                                                                                 | MD.                               |  |
| Germany                                                                                 | U. S. A.                                                                                                  |                          |                                                                                                                                                             |                   | Montgomery                                                       |                                                                                                 |                                   |  |
| 10. CITY OR TOWN OF DEATH                                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                          |                                                                                                                                                             |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Olney                                                                                   | Montgomery General Hospital                                                                               |                          |                                                                                                                                                             |                   | Homemaker                                                        |                                                                                                 |                                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |                                                                                                           |                          |                                                                                                                                                             |                   | 13a. STREET ADDRESS                                              |                                                                                                 |                                   |  |
| 13a. STATE                                                                              |                                                                                                           | 13b. COUNTY              |                                                                                                                                                             | 13c. CITY OR TOWN |                                                                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |  |
| Maryland                                                                                |                                                                                                           | Montgomery               |                                                                                                                                                             | Sandy Spr.        |                                                                  | Friends Home 20860                                                                              |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                  |                                                                                                           |                          | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                                                                               |                   |                                                                  |                                                                                                 |                                   |  |
| Belemann                                                                                |                                                                                                           |                          | Adele                                                                                                                                                       |                   |                                                                  |                                                                                                 |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                    |                                                                                                           | 16b. SOCIAL SECURITY NO. |                                                                                                                                                             | 17. INFORMANT     |                                                                  | ADDRESS                                                                                         |                                   |  |
| No                                                                                      |                                                                                                           | 490-50-0944              |                                                                                                                                                             | Leonore Wagner    |                                                                  | 4819 Asbury Place,<br>N.W., Wash., D.C. 20016                                                   |                                   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4029

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) H A S C U D

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

7 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Chronic Lymphatic Leukemia

|                                                                                                                                                                                                                                                                                                                |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                                                               |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 19 70 to Oct. 13 19 83, that (I) (we) lost<br>saw the deceased alive on Oct. 12 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                               |  |
| 22b. SIGNATURE<br>Frederick Moomau, M.D.                                                                                                                                                                                                                                                                       |  |                                                                        |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>10-15-83                                                                                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Frederick Moomau, Md.                                                                                                                                                                                                                                                 |  |                                                                        |  | 22e. ADDRESS                                                                                                                                         |  |                                                                                                                               |  |

|                                                 |           |                                                      |                                            |
|-------------------------------------------------|-----------|------------------------------------------------------|--------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)    | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |
| Cremation                                       | 10/14/83  | Ft. Lincoln Cremat.                                  | Brentwood, P.G., Md.                       |
| 24. FUNERAL DIRECTOR<br>NAME                    |           | 25a. DATE OF BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |                                            |
| Arthur J. ...                                   |           | OCT 18 1983 John J. ...                              |                                            |
| Takoma Fun'l Home, Inc. N.W., Wash., D.C. 20012 |           |                                                      |                                            |

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|                     |               |                       |                    |
|---------------------|---------------|-----------------------|--------------------|
| 100-50-0944         | Leonor Warner | W.W. Wash. D.C. 20015 | 4019 Academy Place |
| Bellemann           | Adelle        |                       |                    |
| Maryland Montgomery | Sammy Spil    | X                     | Friends Home       |
| Germany             | U. S. A.      | XX                    | Honolulu           |
| Female              | White         | June 11, 1895         | 27                 |

50% COTTON  
 BLUE

Takoma Park Home, Inc. N.W. Wash. D.C. 20015  
 101488 Rt. Lincoln Green. Greenwood, P.O., Md.  
 Frederick, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR                                                       |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                      |                                                                                                        | MONTH DAY YEAR                                                                                                                                           |                                                                     | 2b. HOUR                                                       |                                              |
| EUGENE UNGER                                                                                                                                                                                          |                                                                                                        | 10 29 83                                                                                                                                                 |                                                                     | 11 <sup>16</sup> P M                                           |                                              |
| 3. SEX                                                                                                                                                                                                | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 8. IF UNDER 1 YEAR                                             |                                              |
| MALE                                                                                                                                                                                                  | WHITE                                                                                                  | MARCH 12 1903                                                                                                                                            | 80                                                                  | MONTHS DAYS HOURS MIN.                                         |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                             | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                                                |                                              |
| HUNGARY                                                                                                                                                                                               | U.S.A.                                                                                                 |                                                                                                                                                          | MONTGOMERY MD.                                                      |                                                                |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       | 12b. KIND OF BUSINESS OR INDUSTRY                              |                                              |
| ROCKVILLE                                                                                                                                                                                             | HEBREW HOME OF GREATER WASH.                                                                           |                                                                                                                                                          | MANUFACTURER                                                        | TEXTILE MACH                                                   |                                              |
| 13a. STATE                                                                                                                                                                                            | 13b. COUNTY                                                                                            | 13c. CITY OR TOWN                                                                                                                                        | 13d. INSIDE CITY LIMITS?                                            | 13e. STREET ADDRESS                                            |                                              |
| MD.                                                                                                                                                                                                   | MONTG.                                                                                                 | ROCKVILLE                                                                                                                                                | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 6121 MONTROSE RD. 20852                                        |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                     | 15. MOTHER'S MAIDEN NAME                                                                               |                                                                                                                                                          | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)    |                                                                |                                              |
| MARTIN                                                                                                                                                                                                | HANNAH GROSZ                                                                                           |                                                                                                                                                          | NO NONE                                                             |                                                                |                                              |
| 16b. SOCIAL SECURITY NO.                                                                                                                                                                              |                                                                                                        | 17. INFORMANT                                                                                                                                            |                                                                     |                                                                |                                              |
| 086-10-4310                                                                                                                                                                                           |                                                                                                        | MARCEL UNGER                                                                                                                                             |                                                                     |                                                                |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                |                                              |
| IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST                                                                                                                                                         |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                |                                              |
| 1519 DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF STOMACH METASTATIC TO LUNGS                                                                                                                      |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                | 1 month                                      |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                    |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DIABETES MELLITUS                                                    |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |                                                                                                                                                          | 20a. AUTOPSY?                                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                              |
|                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                              |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                      | 21b. TIME OF INJURY                                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |                                                                     |                                                                |                                              |
|                                                                                                                                                                                                       | HOUR A.M. MONTH DAY YEAR                                                                               |                                                                                                                                                          |                                                                     |                                                                |                                              |
|                                                                                                                                                                                                       | P.M. 19                                                                                                |                                                                                                                                                          |                                                                     |                                                                |                                              |
| 21d. INJURY OCCURRED                                                                                                                                                                                  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                     | 21f. LOCATION                                                                                                                                            |                                                                     |                                                                |                                              |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                     |                                                                                                        | STREET CITY OR TOWN COUNTY STATE                                                                                                                         |                                                                     |                                                                |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 09 29 19 83 to 09 29 19 83, that (I) (we) lost saw the deceased alive on above (I) (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                                     |                                                                |                                              |
| 22b. SIGNATURE                                                                                                                                                                                        | DEGREE                                                                                                 | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               | 22c. DATE SIGNED                                                    |                                                                |                                              |
|                                                                                                                                                                                                       | MD                                                                                                     |                                                                                                                                                          | 10/30/83                                                            |                                                                |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                 | 22e. ADDRESS                                                                                           |                                                                                                                                                          | 22f. DATE REC'D. BY REGISTRAR                                       |                                                                |                                              |
| ROBERT I. ROSENBERG, MD                                                                                                                                                                               | 1131 UNIVERSITY BLVD W, SILVER SPRING, MD                                                              |                                                                                                                                                          | 22g. REGISTRAR'S SIGNATURE                                          |                                                                |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                             | 23b. DATE                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       | 23d. LOCATION                                                       |                                                                |                                              |
| BURIAL                                                                                                                                                                                                | 11-1-83                                                                                                | BETH ISRAEL CEMETERY                                                                                                                                     | WOODBRIDGE, N.J.                                                    |                                                                |                                              |
| 24. FUNERAL DIRECTOR'S NAME                                                                                                                                                                           |                                                                                                        | 24b. ADDRESS                                                                                                                                             |                                                                     | 24c. DATE REC'D. BY REGISTRAR                                  |                                              |
| DANZANSKY-GOLDBERG MEM CHP.                                                                                                                                                                           |                                                                                                        | 170 ROCKVILLE PK, ROCKVILLE MD                                                                                                                           |                                                                     | NOV 04 1983                                                    |                                              |

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JAN 19 1944

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                      |                                                     |                                                                                                                                                             |  |                                                                                                                                    |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Salvatrice caruso Valenti</i>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                      | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>10/13/83</i> |                                                                                                                                                             |  | 2b. HOUR<br><i>11:03 PM</i>                                                                                                        |  |
| 3. SEX<br><i>Female</i>                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br><i>White</i>                                                                                                              |                                                     | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>10/1/95</i>                                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><i>88</i>                                                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>SICILY, ITALY</i>                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                        |                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.                                                                      |  |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Holy Cross Hospital</i> |                                                     | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Own Home</i>                                                                               |  |
| 13a. STATE<br><i>Florida</i>                                                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY<br><i>BROWARD</i>                                                                                                        |                                                     | 13c. CITY OR TOWN<br><i>Pompano Beach</i>                                                                                                                   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Salvatore Caruso</i>                                                                                                                                                                                                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Grazia Longo</i>                                                                    |                                                     | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>                                                  |  |                                                                                                                                    |  |
| 16b. SOCIAL SECURITY NO.<br><i>577-32-9279</i>                                                                                                                                                                                                                                                                                                                                                |  | 17. INFORMANT ADDRESS<br><i>11 419 Allview Drive Beltsville, Md. 20705</i><br><i>Salvatore C. Valenti - Son</i>                      |                                                     |                                                                                                                                                             |  |                                                                                                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><i>5520 IMMEDIATE CAUSE (a) Pulmonary embolus</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Sinus &amp; debility</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis and 2 previous procedures</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>10-14 days</i> |  |                                                                                                                                      |                                                     |                                                                                                                                                             |  |                                                                                                                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><i>Porting @ + 10 hyp parathroid immobilization &amp; 1 cancer @ Fem. 1/Heum</i>                                                                                                                                                                          |  |                                                                                                                                      |                                                     |                                                                                                                                                             |  |                                                                                                                                    |  |
| 19a. DATE OF OPERATION<br><i>10/6/83 + 10/2/83</i>                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>My Fx &amp; near. Fem. Heum</i>                                               |                                                     | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                            |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>                                                                       |                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                                    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><i>10/5/83</i>                                                |                                                     | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><i>10/13 83</i>                                                                                           |  | 22a. DATE SIGNED<br><i>10/14/83</i>                                                                                                |  |
| 22b. I certify that (I) (this hospital) attended the deceased from <i>10/5/83</i> to <i>10/13 83</i> , that (I) (we) lost <i>10/13 83</i> above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                          |  |                                                                                                                                      |                                                     |                                                                                                                                                             |  |                                                                                                                                    |  |
| 22b. SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                          |  | 22c. DEGREE<br><i>PHYSICIAN</i>                                                                                                      |                                                     | 22d. ADDRESS<br><i>7915 Parkman Dr. Urtown</i>                                                                                                              |  | 22e. DATE SIGNED<br><i>10/14/83</i>                                                                                                |  |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>M. E. Miller</i>                                                                                                                                                                                                                                                                                                                                  |  | 23a. BURIAL, CREMATION, REMOVAL (PRECISE)<br><i>Burial</i>                                                                           |                                                     |                                                                                                                                                             |  |                                                                                                                                    |  |
| 23b. DATE<br><i>10/17/83</i>                                                                                                                                                                                                                                                                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Gate of Heaven Cem.</i>                                                                     |                                                     | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Silver Spring, Mont. Md.</i>                                                                                  |  | 24. FUNERAL DIRECTOR NAME<br><i>Francis J. Collins</i>                                                                             |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><i>500 University Blvd. W. Silver Spring, Md.</i>                                                                                                                                                                                                                                                                                                             |  | 25. DATE RECD. BY REGISTRAR<br><i>OCT 21 1983</i>                                                                                    |                                                     |                                                                                                                                                             |  |                                                                                                                                    |  |

500 University Blvd. W. Silver Spring, Md.  
Francis J. Collins

Francis  
11/17/82  
Gate of Heaven Com.  
Silver Spring, Md.

*[Faint, mostly illegible handwritten notes and signatures]*

No. 577-37-9279 Salvatore C. Valenti - 2012  
1110 Allison Drive N.E. 2012  
Salvatore C. Valenti  
Carmelo  
Carmela  
London

Francis  
BROWNT Thompson Beach  
940 North East 25th Ave. 33062  
Household  
Carmel Home

SICILY, ITALY  
W.S.A.  
M. 10  
VXX 22



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                |  |                                                                                     |  |                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                            |  | FIRST Gladys H. MIDDLE Verwiebe LAST                                                |  | 2a. DATE OF DEATH<br>OF ESTI-<br>MATED                                                                                                                                                                                                                                          |  | MONTH DAY YEAR                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 2b. HOUR                                                                                                   |  |
| 3. SEX                                                                                                                                                         |  | 4. RACE                                                                             |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR                                                                                                                                                                                                                                              |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?                                                        |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10. CITY OR TOWN OF DEATH                                                                                  |  |
| England                                                                                                                                                        |  | U. S. A.                                                                            |  | Retired                                                                                                                                                                                                                                                                         |  | Teacher                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                                                                                               |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                                |  | 13a. STATE                                                                                                                                                                                                                                                                      |  | 13b. COUNTY                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 13c. CITY OR TOWN                                                                                          |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                |  | 13e. STREET ADDRESS                                                                 |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                             |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)                                      |  |
| 16b. SOCIAL SECURITY NO.                                                                                                                                       |  | 17. INFORMANT                                                                       |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u><br>4291<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause lost. |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                                                                                                                                                           |  | 19a. DATE OF OPERATION                                                                                     |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                              |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                                                                                                                                                                                                                                                                                                                                                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                               |  | 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  | 23a. NAME OF CEMETERY OR CREMATORY                                                                         |  |
| 23b. DATE                                                                                                                                                      |  | 23c. LOCATION<br>CITY OR TOWN COUNTY STATE                                          |  | 23d. DATE REC'D. BY REGISTRAR                                                                                                                                                                                                                                                   |  | 23e. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 23f. DATE REC'D. BY REGISTRAR                                                                              |  |
| 23g. BURIAL, CREMATION, REMOVAL                                                                                                                                |  | 23h. DATE                                                                           |  | 23i. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                                                                                              |  | 23j. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                                                                                                                                |  | 23k. DATE REC'D. BY REGISTRAR                                                                              |  |
| 23l. REGISTRAR'S SIGNATURE                                                                                                                                     |  | 23m. DATE REC'D. BY REGISTRAR                                                       |  | 23n. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                      |  | 23o. DATE REC'D. BY REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 23p. REGISTRAR'S SIGNATURE                                                                                 |  |

MEDICAL CERTIFICATION

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion  
death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE John P. Rogers M.D. Dep MEDICAL EXAMINER

DATE SIGNED Oct 21/1983

EXAMINER'S NAME  
(TYPE OR PRINT)

ADDRESS

23g. BURIAL, CREMATION, REMOVAL Cremation. 23h. DATE 10/21/83 23i. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory 23j. LOCATION Bladensburg Rd. P. G. Md  
23k. DATE REC'D. BY REGISTRAR OCT 24 1983 23l. REGISTRAR'S SIGNATURE John J. Conish

George E. ...

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Received

London

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|                                                                                   |  |                                                                                                                                             |                                                               |                                                                                                                                                             |  |                                                                                                 |  |                                                               |  |
|-----------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HELEN HENRIETTA VOSS</b>                |  |                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 3, 1983</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>11:00pm</b>                                                                      |  |                                                               |  |
| 3. SEX<br><b>Female</b>                                                           |  | 4. RACE<br><b>White</b>                                                                                                                     |                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>November 16, 1926</b>                                                                                              |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.                                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               |                                                               | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY COUNTY</b> MD.                            |  |                                                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6804 Fairfax Road 20814</b> |                                                               |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>              |  |
| 13a. STATE<br><b>Maryland</b>                                                     |  | 13b. COUNTY<br><b>Montgomery</b>                                                                                                            |                                                               | 13c. CITY OR TOWN<br><b>Bethesda</b>                                                                                                                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>6804 Fairfax Road 20814</b>         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Werner Furn</b>                      |  |                                                                                                                                             |                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hildegard Jakobson</b>                                                                                  |  |                                                                                                 |  |                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>153-20-2186</b>                                                                                              |                                                               | 17. INFORMANT<br><b>Mr. Allen Voss</b>                                                                                                                      |  | ADDRESS<br><b>Same as item 13</b>                                                               |  |                                                               |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Respiratory failure (secondary to B)**

1629  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Small cell carcinoma of lung with widespread metastases.**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

**16 months**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **16**

MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                            |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                                          |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                 |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                        |  |                                                                                                                                          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                                                                          |  |
| 22a. I certify that (x) (this hospital) attended the deceased from <b>June 22, 1982</b> to <b>October 3, 1983</b> that (x) (we) lost<br>saw the deceased alive on <b>September 16, 1983</b> , and that in (xx) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (by) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                                          |  |
| 22b. SIGNATURE<br><b>Dan L. Longo MD</b>                                                                                                                                                                                                                                                                                                                   |  |                                                                        |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10/4/83</b>                                                                                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAN L. LONGO, M.D.</b>                                                                                                                                                                                                                                                                                         |  |                                                                        |  | 22e. ADDRESS<br><b>National Institutes of Health, 9000<br/>Rockville Pike, Bethesda, Maryland 20205</b>                                              |  |                                                                                                                                          |  |

|                                                                                                                   |  |                               |  |                                                                   |  |                                                                        |  |
|-------------------------------------------------------------------------------------------------------------------|--|-------------------------------|--|-------------------------------------------------------------------|--|------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                  |  | 23b. DATE<br><b>10/5/1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland Maryland</b> |  |
| 24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons Inc.</b><br>NAME ADDRESS<br><b>5130 Wisc. Ave., N.W. Wash., D.C.</b> |  |                               |  | 25. DATE RECEIVED BY REGISTRAR<br><b>OCT 10 1983</b>              |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Gawler</b>                    |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

10/7/1983  
Johnson & Johnson Inc.  
New York, N.Y. 10001

Attention: Mr. Johnson  
10/7/1983

x

xx

x

Enclosed for the attention of the  
personnel in charge of the  
laboratory (see page 2)

No

Johnson

Smith

Hill

Smith

1802

Johnson

Smith

New York

U.S.A.

x

11:00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                     |  |                                                                                                                                                  |  | REG. NO.                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR <b>Julia P. Voss</b>                                                                                                                                                                                                              |  |                                                                                                                                                  |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JULIA PERKINS VOSS</b>                                                                                                                                                                          |  |                                                                                                                                                  |  | 10-18-83                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                         |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                  |  | 4. RACE<br><b>White</b>                                                                                                                          |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Sept. 22, 1898</b>                                                                                                                                                                                                                                                                                                                                                                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>85</b>                                                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>CO</b>                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                       |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>Kensington</b>                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Kensington Gardens Nursing Home</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                                                                                                                                                                                                                                                                                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                                                    |  |
| 13a. STATE<br><b>Md. 20842</b>                                                                                                                                                                                                                           |  | 13b. COUNTY<br><b>Montgomery</b>                                                                                                                 |  | 13c. CITY OR TOWN<br><b>Dickerson</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><b>21521 Peach Tree Rd. 20842</b>                                                                                                                                                                                                 |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Edwin H. Perkins</b>                                                                                   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ula B. France</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>               |  |
| 16b. SOCIAL SECURITY NO.<br><b>521-03-4012</b>                                                                                                                                                                                                           |  | 17. INFORMANT ADDRESS<br><b>Greydon S. Tolson Same as item # 13</b>                                                                              |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>arteriosclerotic cardiovascular disease</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>years</b> |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)                                                                                                                     |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                 |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                        |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                   |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                         |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>10/18/83</b> to <b>10/18/83</b> , that (we) lost saw the deceased (signature) above, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                         |  |
| 22b. SIGNATURE<br><b>B.N. ROSENBAUM</b>                                                                                                                                                                                                                  |  | DEGREE<br><b>M.D.</b>                                                                                                                            |  | ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                  |  | 22c. DATE SIGNED<br><b>10/18/83</b>                                                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B.N. ROSENBAUM</b>                                                                                                                                                                                           |  | 22e. ADDRESS<br><b>3720 FARRAGUT AVE KENSINGTON, MD 20895</b>                                                                                    |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                         |  |
| 23b. DATE<br><b>10/19/83</b>                                                                                                                                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>                                                                                |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Suitland, MD</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 24. FUNERAL DIRECTOR<br><b>Joseph Gawler's Sons, Inc.</b>                                                               |  |
| 24a. NAME<br><b>5130 Wisc. Ave. N.W. Wash., DC 20016</b>                                                                                                                                                                                                 |  | 24b. ADDRESS                                                                                                                                     |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 24 1983</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                        |  |

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## MEDICAL CERTIFICATION

DHMH - 16 50M 4/B2  
(VRA 15, 4)



UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

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UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                              |                                                                                      |                                                                              |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                |                                                                        |                                                                                                                                                             | REG. NO.                                                                                                                                             |                                                                                              |                                                                                      |                                                                              |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Sterling L. Wallace</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                |                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 21, 1983</b>                                                                                       |                                                                                              |                                                                                      | 2b. HOUR<br><b>1:35P<sub>M</sub></b>                                         |                                                                                                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>White</b>                                                                                                                        |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>February 13, 1893</b>                                                                                              |                                                                                                                                                      |                                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.                                    |                                                                              | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Georgia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                      |                                                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery Co.</b> MD.                    |                                                                              |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sligo Gardens Nursing Home</b> |                                                                        |                                                                                                                                                             |                                                                                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sup. Univ. of Md.</b> |                                                                                      |                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Poultry</b>                                                                        |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                |                                                                        |                                                                                                                                                             | 13b. COUNTY<br><b>P.G.</b>                                                                                                                           |                                                                                              | 13c. CITY OR TOWN<br><b>Beltsville</b>                                               |                                                                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William C. Wallace</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Josephine Unknown</b>                                                                            |                                                                                              |                                                                                      |                                                                              |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes-Army</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                |                                                                        |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br><b>W.W.I 577-03-5763</b>                                                                                                 |                                                                                              | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Hilda M. Wallace Address Same as No# 13e.</b>    |                                                                              |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4860</b> IMMEDIATE CAUSE (a) <b>Acute pneumonitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Congestive heart failure: Arteriosclerotic cardiovascular disease</b> |  |                                                                                                                                                |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                              |                                                                                      |                                                                              |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                                                                                      |                                                                                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                                                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |                                                                                      |                                                                              |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                            |                                                                                      |                                                                              |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>October 1, 1969</b> , to <b>October 21, 1983</b> , that (I) (we) lost<br>saw the deceased alive on <b>October 21, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                                       |  |                                                                                                                                                |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                              |                                                                                      |                                                                              |                                                                                                                            |  |
| 22b. SIGNATURE<br><i>Carl J. Houmann</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                |                                                                        |                                                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                              |                                                                                      | 22c. DATE SIGNED<br><b>Oct. 21, 1983</b>                                     |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Carl J. Houmann, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br><b>4404 Queensbury Rd., Riverdale, Md. 20737</b>                                                                                     |                                                                                              |                                                                                      |                                                                              |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                | 23b. DATE<br><b>Oct. 24, 1983</b>                                      |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>                                                                                    |                                                                                              |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood P.G. Maryland</b> |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>F. Gasch's Sons F.H. P.A. Hyattsville, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                |                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 26 1983</b>                                                                                                  |                                                                                              |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><i>John A. Smith</i>                           |                                                                                                                            |  |

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

• 977 507

Abstracts from the following journals are included:

2025 RELEASE UNDER E.O. 14176

4070 JOURNAL OF CLIMATE

V. Gesch. u. Sonst. v. H. v. A. Hyattsville, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP \_\_\_\_\_

DHMH - 16 50M 4/82  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                                   |  |                                                                                                                         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                         |  | REG. NO. 27897                                                                                         |  |                                                                                                                                                          |  |                                                                     |  |                                                                                   |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                               |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                   |  | LAST                                                                |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                  |  | 2b. HOUR                                                                                                                |  |
| ROSE                                                                                                                                                                                                                                                                                                           |  | WHITMAN                                                                                                |  |                                                                                                                                                          |  |                                                                     |  | 10 30 83                                                                          |  | 1:37 A M                                                                                                                |  |
| 3. SEX                                                                                                                                                                                                                                                                                                         |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR MONTHS DAYS                                                       |  | IF UNDER 24 HRS HOURS MIN.                                                                                              |  |
| FEMALE                                                                                                                                                                                                                                                                                                         |  | WHITE                                                                                                  |  | APRIL 8 1902                                                                                                                                             |  | 81 YRS                                                              |  |                                                                                   |  |                                                                                                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                                                                   |  |                                                                                                                         |  |
| LITHUANIA                                                                                                                                                                                                                                                                                                      |  | U.S.A.                                                                                                 |  |                                                                                                                                                          |  | MONTGOMERY MD.                                                      |  |                                                                                   |  |                                                                                                                         |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                          |  |                                                                     |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |
| ROCKVILLE                                                                                                                                                                                                                                                                                                      |  | HEBREW HOME OF GREATER WASH.                                                                           |  |                                                                                                                                                          |  |                                                                     |  | HOMEMAKER                                                                         |  | HOME                                                                                                                    |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                                   |  |                                                                                                                         |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                                                               |  |                                                                                                                         |  |
| MD.                                                                                                                                                                                                                                                                                                            |  | MONTGOMERY                                                                                             |  | ROCKVILLE                                                                                                                                                |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 6121 MONTROSE RD. (20852)                                                         |  |                                                                                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                            |  |                                                                                                        |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                                                                               |  |                                                                     |  |                                                                                   |  |                                                                                                                         |  |
| SAMUEL LIEBERMAN                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  | GOLDIE SHOFNIS                                                                                                                                           |  |                                                                     |  |                                                                                   |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.                                                                               |  | 17. INFORMANT                                                                                                                                            |  | ADDRESS                                                             |  |                                                                                   |  |                                                                                                                         |  |
| NONE                                                                                                                                                                                                                                                                                                           |  | 572-56-0494                                                                                            |  | MRS. GRETTA MAGNUS                                                                                                                                       |  | 13210 COLLINGSWOOD SILVER SPRING,                                   |  |                                                                                   |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                            |  |
| IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST                                                                                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                                   |  |                                                                                                                         |  |
| 2900 DUE TO, OR AS A CONSEQUENCE OF (b) PROBABLE SEPSIS & PNEUMONIA                                                                                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                                   |  | 3 days                                                                                                                  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) SENILE DEMENTIA, MULTIPLE CVA                                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                                   |  | 3 years                                                                                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                                   |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |  |                                                                     |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                             |  |                                                                                                        |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                                                                             |  |                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)     |  |                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                |  |                                                                                                        |  | P.M. 19                                                                                                                                                  |  |                                                                     |  |                                                                                   |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                         |  |                                                                                                        |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  |                                                                     |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                                   |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 14 1981 to Oct 30 1983, that (I) (we) last saw the deceased alive on Oct 30 1983, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                                   |  |                                                                                                                         |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  | DEGREE                                                                                                                                                   |  |                                                                     |  | 22c. DATE SIGNED                                                                  |  |                                                                                                                         |  |
| Robert C. Rosenberg, MD                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  | MD                                                                                                                                                       |  |                                                                     |  | 10/30/83                                                                          |  |                                                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                          |  |                                                                                                        |  | 22e. ADDRESS                                                                                                                                             |  |                                                                     |  |                                                                                   |  |                                                                                                                         |  |
| ROBERT C. ROSENBERG, MD                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  | 1131 UNIVERSITY BLVD W, SILVER SPRING, MD 20912                                                                                                          |  |                                                                     |  |                                                                                   |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                      |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |                                                                                   |  |                                                                                                                         |  |
| BURIAL                                                                                                                                                                                                                                                                                                         |  | 11-1-83                                                                                                |  | BETH SHOLOM CEM.                                                                                                                                         |  | DISTRICT HEIGHTS, MD.                                               |  |                                                                                   |  |                                                                                                                         |  |
| 24. FUNERAL DIRECTOR'S NAME                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE                                                        |  |                                                                                                                         |  |
| P170 ROCKVILLE PK. ROCKVILLE MD DANZANSKY-GOLDBERG MEM CHQ. INC.                                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                          |  | NOV 03 1983                                                         |  | John J. Conner                                                                    |  |                                                                                                                         |  |



ROCKVILLE, MD. DISTRICT  
BETH SHAWAN CEM. DISTRICT

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

27898

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                               |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                                        |  |                                              |  |                                                                                                |  |                     |  |                               |  |                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|------------------------------------------------------------------------------------------------|--|---------------------|--|-------------------------------|--|------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                               |  | FIRST<br><b>Ronald</b>                        |  | MIDDLE<br><b>Franklin</b>                                                                                                                                   |  | LAST<br><b>Wicks</b>                                                                 |  | 2b. DATE KNOWN OF DEATH                                                                                                                |  | MONTH<br><b>10</b>                           |  | DAY<br><b>3</b>                                                                                |  | YEAR<br><b>1983</b> |  | 2d. HOUR<br><b>4:22</b>       |  |                                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>White</b>                       |  | 5. DATE OF BIRTH<br>MONTH<br><b>1</b> DAY<br><b>22</b> YEAR<br><b>37</b>                                                                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>46</b> YRS.                                    |  | IF UNDER 24 HRS.<br>MONTHS<br><b>0</b> DAYS<br><b>0</b> HOURS<br><b>0</b> MIN.                                                         |  | 7c. DATE PRONOUNCED DEAD<br><b>10 3 1983</b> |  | 2d. HOUR<br><b>4:02</b>                                                                        |  |                     |  |                               |  |                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>                                                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONT GOMERY</b> MD                        |  |                                                                                                                                        |  |                                              |  |                                                                                                |  |                     |  |                               |  |                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>CHEY CHASE</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5609 MONT GOMERY ST</b>                       |  |                                                                                      |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Data Base Admin.</b>                                               |  |                                              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NTH</b>                                                |  |                     |  |                               |  |                                                            |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 13b. COUNTY<br><b>MONT GOMERY</b>             |  | 13c. CITY OR TOWN<br><b>CHEY CHASE</b>                                                                                                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5609 MONT GOMERY ST</b>                                                                                      |  |                                              |  |                                                                                                |  |                     |  |                               |  |                                                            |  |
| 14. FATHER'S NAME<br>FIRST<br><b>Charles</b> MIDDLE<br><b>F.</b> LAST<br><b>Wicks</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>(Unknown)</b> MIDDLE<br><b></b> LAST<br><b>Zeigler</b>                                                              |  |                                                                                      |  |                                                                                                                                        |  |                                              |  |                                                                                                |  |                     |  |                               |  |                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                               |  | 16b. SOCIAL SECURITY NO.<br><b>263-68-7658</b>                                                                                                              |  | 17. INFORMANT<br><b>Diane T. Wicks. Same as item 13.</b>                             |  |                                                                                                                                        |  |                                              |  |                                                                                                |  |                     |  |                               |  |                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>EXSANGUINATION</b><br>9560<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>LACERATION LEFT WRIST</b><br>(c) <b>DEPRESSION</b>                                                                                                                       |  |                                               |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                                        |  |                                              |  |                                                                                                |  |                     |  |                               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>HY.</b> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>CHRONIC LOW BACK SYNDROME</b>                                                                                                                                                                                                                                                                           |  |                                               |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                                        |  |                                              |  |                                                                                                |  |                     |  |                               |  |                                                            |  |
| 19a. DATE OF OPERATION<br><b>-</b>                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>-</b>                                                                                               |  |                                                                                      |  |                                                                                                                                        |  |                                              |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |                     |  |                               |  |                                                            |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    |  |                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>10 3 1983</b>                                                                                    |  |                                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>LACERATION OF WRIST</b>                            |  |                                              |  |                                                                                                |  |                     |  |                               |  |                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                              |  |                                               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>HOME</b>                                                                                  |  |                                                                                      |  | 21f. LOCATION<br>STREET<br><b>5609 MONTGOMERY ST</b> CITY OR TOWN<br><b>CHEY CHASE</b> COUNTY<br><b>MONT GOMERY</b> STATE<br><b>MD</b> |  |                                              |  |                                                                                                |  |                     |  |                               |  |                                                            |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |                                               |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                                        |  |                                              |  |                                                                                                |  |                     |  |                               |  |                                                            |  |
| ACTUAL SIGNATURE<br><b>Francis C. Mayle</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                               |  | TITLE (SPECIFY)<br><b>Dr.</b>                                                                                                                               |  |                                                                                      |  | M.D.<br><b>Dr.</b>                                                                                                                     |  |                                              |  | MEDICAL EXAMINER<br><b>Dr.</b>                                                                 |  |                     |  | DATE SIGNED<br><b>10/3/83</b> |  |                                                            |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Francis C. Mayle</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                               |  | ADDRESS<br><b>8200 Wisconsin Ave Bethesda MD</b>                                                                                                            |  |                                                                                      |  |                                                                                                                                        |  |                                              |  |                                                                                                |  |                     |  |                               |  |                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                        |  |                                               |  | 23b. DATE<br><b>10/6/1983</b>                                                                                                                               |  |                                                                                      |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Memorial Park Cem.</b>                                                               |  |                                              |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Rockville</b> COUNTY<br><b>Maryland</b> STATE<br><b>Md</b> |  |                     |  |                               |  |                                                            |  |
| 24. FUNERAL DIRECTOR<br><b>Joseph Gawler's Sons Inc.</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                               |  |                                                                                                                                                             |  |                                                                                      |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 10 1983</b>                                                                                    |  |                                              |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                            |  |                     |  |                               |  |                                                            |  |
| 5130 Wisc Ave., N.W. Wash., D.C.                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                               |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                                        |  |                                              |  |                                                                                                |  |                     |  |                               |  |                                                            |  |

White

xx

U.S.A.

Ohio

MIN. 1940-1941

2015

Charles (Thomas) T. Ticks

201-75-7500 Ticks, Thomas T. 1940-1941

10/10/10 Memorial Park Cemetery, Rockville, Maryland

Local Telephone Inc.

10/10/10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                      |  | REG. NO. 83 27899                                                                                                                                           |  |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Frank L. Widman</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                      |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>Oct. 23, 1983</b>                                                                                                       |  |                                                                                                                            |  |
| 3. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                      |  | 2b. HOUR <b>3:20AM</b>                                                                                                                                      |  |                                                                                                                            |  |
| 4. RACE <b>CAUC</b>                                                                                                                                                                                                                                                                                                                                                                               |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>9 29 19</b>                                                                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS                                                                                                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Colorado</b>                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.                                                                 |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>                                                                             |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>US Gov't.</b>                                                                         |  |
| 13a. STATE <b>MD</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                      |  | 13b. COUNTY <b>Montgomery</b>                                                                                                                               |  |                                                                                                                            |  |
| 13c. CITY OR TOWN <b>Silver Spring</b>                                                                                                                                                                                                                                                                                                                                                            |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                         |  | 13e. STREET ADDRESS <b>1606 Wilson Place 20910</b>                                                                                                          |  |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Frank</b>                                                                                                                                                                                                                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Oliver Cooper</b>                                                                   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b>                                                                             |  |                                                                                                                            |  |
| 16b. SOCIAL SECURITY NO. <b>524-12-0824</b>                                                                                                                                                                                                                                                                                                                                                       |  | 17. INFORMANT <b>Elanor Widman (wife)</b>                                                                                            |  | ADDRESS <b>1606 Wilson Pl. Silver Spring MD</b>                                                                                                             |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory and Cordiac Arrest</b><br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cerebrovascular Accident</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                              |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>October 17, 1983</b> to <b>October 23, 1983</b> , that (I) (we) lost<br>saw the deceased alive on <b>October 22, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                     |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE <b>Poth, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                  |  | DEGREE                                                                                                                               |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED <b>10-23-83</b>                                                                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Phillip W. Poth, M.D.</b>                                                                                                                                                                                                                                                                                                                                |  | 22e. ADDRESS <b>Suite 240, 818 18th St. N.W.<br/>Washington, D.C. 20006</b>                                                          |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Removal</b>                                                                                                                                                                                                                                                                                                                                       |  | 23b. DATE <b>October 24, 83</b>                                                                                                      |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Geo. Wash. Med. School</b>                                                                                            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>                                                         |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>225 Missouri Ave</b> ADDRESS <b>Columbia Mortuary Service Washington, D.C.</b>                                                                                                                                                                                                                                                                                    |  |                                                                                                                                      |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 31 1983</b>                                                                                                            |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>                                                                        |  |

BP

US Gov't.

Sliver

WM II 521-12-0821 Elmer Wilson (wife) 1606 Wilson Pl. Spring

October 24, 1968, Washington, D.C.

Removal

Columbia Northern Service, Washington, D.C.  
222 Maryland Ave

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                 |  |                                                                                                        |                   |                                                                                                                                                          |      |                                                                     |      |                                                                |       |                                              |   |            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------|---------------------------------------------------------------------|------|----------------------------------------------------------------|-------|----------------------------------------------|---|------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                               |  |                                                                                                        | REG. NO.          |                                                                                                                                                          |      |                                                                     |      |                                                                |       |                                              |   |            |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                     |  |                                                                                                        | 2a. DATE OF DEATH |                                                                                                                                                          |      | MONTH                                                               |      | DAY                                                            |       | YEAR                                         |   | 2b. HOUR   |  |
| LEONARD John WILBERT                                                                                                                                                                                                                                                                                                 |  |                                                                                                        | 10                |                                                                                                                                                          | -31- |                                                                     | 1983 |                                                                | 0740A |                                              | M |            |  |
| 3. SEX                                                                                                                                                                                                                                                                                                               |  | 4. RACE                                                                                                |                   | 5. DATE OF BIRTH                                                                                                                                         |      | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |      | IF UNDER 1 YEAR                                                |       | IF UNDER 24 HRS.                             |   |            |  |
| MALE                                                                                                                                                                                                                                                                                                                 |  | Cauc                                                                                                   |                   | 11 21 1902                                                                                                                                               |      | 81                                                                  |      | MONTHS                                                         |       | DAYS                                         |   | HOURS MIN. |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |      |                                                                |       |                                              |   |            |  |
| Wisc.                                                                                                                                                                                                                                                                                                                |  | U.S.A.                                                                                                 |                   |                                                                                                                                                          |      | MONTGOMERY, MD.                                                     |      |                                                                |       |                                              |   |            |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |      | 12b. KIND OF BUSINESS OR INDUSTRY                                   |      |                                                                |       |                                              |   |            |  |
| BETHESDA                                                                                                                                                                                                                                                                                                             |  | FERWOOD NURSING HOME                                                                                   |                   | AUDITOR                                                                                                                                                  |      | U.S. GOVT.                                                          |      |                                                                |       |                                              |   |            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                         |  | 13b. CITY OR TOWN                                                                                      |                   | 13c. INSIDE CITY LIMITS?                                                                                                                                 |      | 13d. STREET ADDRESS                                                 |      |                                                                |       |                                              |   |            |  |
| WASH. D.C.                                                                                                                                                                                                                                                                                                           |  | WASH. D.C.                                                                                             |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                      |      | 3224 MILITARY RD., NW.                                              |      |                                                                |       |                                              |   |            |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)                                                                                                                                                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)                                                           |                   |                                                                                                                                                          |      |                                                                     |      |                                                                |       |                                              |   |            |  |
| JOHN                                                                                                                                                                                                                                                                                                                 |  | WILBERT                                                                                                |                   | RENA                                                                                                                                                     |      | (UNKNOWN)                                                           |      |                                                                |       |                                              |   |            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.                                                                               |                   | 17. INFORMANT                                                                                                                                            |      | ADDRESS                                                             |      |                                                                |       |                                              |   |            |  |
| No                                                                                                                                                                                                                                                                                                                   |  | 213-44-6525                                                                                            |                   | WIFE - SADIE J. WILBERT - SAME AS 13                                                                                                                     |      |                                                                     |      |                                                                |       |                                              |   |            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                |  |                                                                                                        |                   |                                                                                                                                                          |      |                                                                     |      |                                                                |       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |            |  |
| 1579 IMMEDIATE CAUSE (a) Cardiac-respiratory failure                                                                                                                                                                                                                                                                 |  |                                                                                                        |                   |                                                                                                                                                          |      |                                                                     |      |                                                                |       | 1 day                                        |   |            |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of pancreas                                                                                                                                                                                                                                                             |  |                                                                                                        |                   |                                                                                                                                                          |      |                                                                     |      |                                                                |       |                                              |   |            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) biliary obstruction.                                                                                                                                                                                              |  |                                                                                                        |                   |                                                                                                                                                          |      |                                                                     |      |                                                                |       |                                              |   |            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                     |  |                                                                                                        |                   |                                                                                                                                                          |      |                                                                     |      |                                                                |       |                                              |   |            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |                   |                                                                                                                                                          |      | 20a. AUTOPSY?                                                       |      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |       |                                              |   |            |  |
|                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |                   |                                                                                                                                                          |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |      | YES <input type="checkbox"/> NO <input type="checkbox"/>       |       |                                              |   |            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.                                                      |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |      |                                                                     |      |                                                                |       |                                              |   |            |  |
|                                                                                                                                                                                                                                                                                                                      |  | 19                                                                                                     |                   |                                                                                                                                                          |      |                                                                     |      |                                                                |       |                                              |   |            |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |      |                                                                     |      |                                                                |       |                                              |   |            |  |
|                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |                   |                                                                                                                                                          |      |                                                                     |      |                                                                |       |                                              |   |            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from March 19 83 to Oct 31 1983, that (I) (we) lost saw the deceased alive on October 28, 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |                   |                                                                                                                                                          |      |                                                                     |      |                                                                |       |                                              |   |            |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                       |  | DEGREE                                                                                                 |                   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |      | 22c. DATE SIGNED                                                    |      |                                                                |       |                                              |   |            |  |
| Earl H. Mitchell M.D.                                                                                                                                                                                                                                                                                                |  |                                                                                                        |                   |                                                                                                                                                          |      |                                                                     |      |                                                                |       |                                              |   |            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                |  | 22e. ADDRESS                                                                                           |                   |                                                                                                                                                          |      |                                                                     |      |                                                                |       |                                              |   |            |  |
| EARL H MITCHELL                                                                                                                                                                                                                                                                                                      |  | 2023 R St N.W. Wash. D.C.                                                                              |                   |                                                                                                                                                          |      |                                                                     |      |                                                                |       |                                              |   |            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                            |  | 23b. DATE                                                                                              |                   | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |      | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |      |                                                                |       |                                              |   |            |  |
| BURIAL                                                                                                                                                                                                                                                                                                               |  | Nov. 3, 1983                                                                                           |                   | GATE OF HEAVEN CEM                                                                                                                                       |      | SILVER SPRING MD.                                                   |      |                                                                |       |                                              |   |            |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                            |  | ADDRESS                                                                                                |                   | 25a. REC'D BY REGISTRAR                                                                                                                                  |      | 25b. REGISTRAR'S SIGNATURE                                          |      |                                                                |       |                                              |   |            |  |
| James E. [Signature]                                                                                                                                                                                                                                                                                                 |  | WASH. D.C.                                                                                             |                   | NOV 1983                                                                                                                                                 |      | John J. [Signature]                                                 |      |                                                                |       |                                              |   |            |  |



Wisc.

St. A.

Montgomery

Bethesda

Fernando Nursing Home

Wash. D.C.

W. B. B. B.

John

(unknown)

213-44-652 Mrs. - 2nd St. - 2nd St.

No



1/1/1

200%

COLIC

1/1/1



WASH. D.C. 20001  
NOV 1 1983  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                |                                                                      |                                                                                                                                                             |                                         |                                                                                      |                                                                                                 |                                                                                                                            |                                                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Anna M. Williams</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                | 2r. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 / 5 / 83</b>            |                                                                                                                                                             |                                         | 2b. HOUR<br><b>1457</b> M                                                            |                                                                                                 |                                                                                                                            |                                                             |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>CAUCASIAN</b>                                                                                                                    |                                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEBRUARY 26 1902</b>                                                                                               |                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.                                    |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br><b>10 5 14</b>                                                              |                                                             |  |
| 7r. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>                                                                                           |                                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY COUNTY</b> MD.                 |                                                                                                 |                                                                                                                            |                                                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>ROCKVILLE</b>                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Shady Grove Adventist Hosp</b> |                                                                      |                                                                                                                                                             |                                         | 12a. USUAL OCCUPATION<br>(TYPE OF WORKING LIFE)<br><b>BOOKKEEPER</b>                 |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RETAIL</b>                                                                         |                                                             |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                           |  |                                                                                                                                                | 13b. COUNTY<br><b>MONTGOMERY</b>                                     |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>POOLESVILLE</b> |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br><b>18810 RIVER ROAD</b> <b>20837</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES RALEY</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EMMA SHERMAN</b> |                                                                                                                                                             |                                         | 16. ADDRESS<br><b>18801 RIVER RD. POOLESVILLE MD.</b>                                |                                                                                                 |                                                                                                                            |                                                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>577423931</b>                                                                     |                                                                      | 17. INFORMANT<br><b>ELIZABETH LACKEY</b>                                                                                                                    |                                         |                                                                                      |                                                                                                 |                                                                                                                            |                                                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Septic Shock</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Severely Perforated</b><br>Approximate interval between onset and death: <b>2760</b>                            |  |                                                                                                                                                |                                                                      |                                                                                                                                                             |                                         |                                                                                      |                                                                                                 |                                                                                                                            |                                                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                               |  |                                                                                                                                                |                                                                      |                                                                                                                                                             |                                         |                                                                                      |                                                                                                 |                                                                                                                            |                                                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                               |                                                                      |                                                                                                                                                             |                                         | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>10 12 1983</b>                                                                           |                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                         |                                                                                      |                                                                                                 |                                                                                                                            |                                                             |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                         |                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>20428 Germantown Rd Germantown MD 20874</b>                                                         |                                         |                                                                                      |                                                                                                 |                                                                                                                            |                                                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/2/83</b> 19 <b>83</b> , to <b>10/5/83</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>10/5</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                |                                                                      |                                                                                                                                                             |                                         |                                                                                      |                                                                                                 |                                                                                                                            |                                                             |  |
| 22b. SIGNATURE<br><b>H. O. Khianey</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                |                                                                      | DEGREE<br><b>ATTENDING PHYSICIAN</b>                                                                                                                        |                                         | MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |                                                                                                 | 22c. DATE SIGNED                                                                                                           |                                                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HERV. O. KHIANEY</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                |                                                                      | 22e. ADDRESS<br><b>20428 Germantown Rd Germantown MD 20874</b>                                                                                              |                                         |                                                                                      |                                                                                                 |                                                                                                                            |                                                             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br><b>OCT 10, 1983</b>                                                                                                               |                                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Memorial Park</b>                                                                                         |                                         | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rockville MD</b>                    |                                                                                                 | 23e. DATE REC'D. BY REGISTRAR<br><b>OCT 13 1983</b>                                                                        |                                                             |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Robert A. Pumphrey Funeral Homes P.A. Rockville MD</b>                                                                                                                                                                                                                                                                  |  |                                                                                                                                                |                                                                      |                                                                                                                                                             |                                         |                                                                                      |                                                                                                 |                                                                                                                            |                                                             |  |
| 25a. REGISTRAR'S SIGNATURE<br><b>John J. Connelley</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                |                                                                      |                                                                                                                                                             |                                         |                                                                                      |                                                                                                 |                                                                                                                            |                                                             |  |

10/2/01

10/2/01

10

10

X

X

X

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 9 0 2

FOR  
1. STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                   |                                                       |                                                                                                                                                             |  |                                                                                                                                                        |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LYNNE EVANS WILLIS</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 9 83</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>3 A M</b>                                                                                                                               |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><b>Caucasian</b>                                                                                                                       |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 19 42</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>41</b> YRS.                                                                                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Washington, DC</b>                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                                       |                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                                                                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park Md.</b>                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hospital</b> |                                                       |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                                                   |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY<br><b>Annapundel</b>                                                                                                                  |                                                       | 13c. CITY OR TOWN<br><b>Davidsonville</b>                                                                                                                   |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>                                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Arthur Louis EVANS</b>                                                                                                                                                                                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Eleanor Harding</b> <b>Mc</b>                                                            |                                                       | 16. SOCIAL SECURITY NO.<br><b>213-42-9924</b>                                                                                                               |  |                                                                                                                                                        |  |
| 17. INFORMANT<br>ADDRESS<br><b>3307 Royale Glen Ave.</b>                                                                                                                                                                                                                                                                                                             |  | 18. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                      |                                                       |                                                                                                                                                             |  |                                                                                                                                                        |  |
| 19. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                  |                                                       | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>                                                          |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                        |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                                                        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                            |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/7</b> , 19 <b>83</b> , to <b>10/9</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>10/8/83</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                   |                                                       |                                                                                                                                                             |  |                                                                                                                                                        |  |
| 22b. SIGNATURE<br><b>Kathleen McShane</b>                                                                                                                                                                                                                                                                                                                            |  | DEGREE<br><b>MD</b>                                                                                                                               |                                                       | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>10/11/83</b>                                                                                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kathleen McShane</b>                                                                                                                                                                                                                                                                                                     |  | 22e. ADDRESS<br><b>Landover Kaiser George Town Health Plan Landover Md</b>                                                                        |                                                       |                                                                                                                                                             |  |                                                                                                                                                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                        |  | 23b. DATE<br><b>10-12-83</b>                                                                                                                      |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cem.</b>                                                                                            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Silver Spring, Montgomery, MD</b>                                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Beall Funeral Home</b>                                                                                                                                                                                                                                                                                                            |  | 16000 Annapolis Road<br>Bowie, Maryland 20715                                                                                                     |                                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 13 1983</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                                                                                    |  |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Liver Failure - renal failure**

1539  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **colon cancer with metastases**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**3 days**  
**1 month**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**Renal Failure**

|                        |                                                  |                                                                                                    |                                                                                                                                                        |
|------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> |
|------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                          |                                                                        |                                                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |

22a. I certify that (I) (this hospital) attended the deceased from **9/7**, 19 **83**, to **10/9**, 19 **83**, that (I) (we) last saw the deceased alive on **10/8/83**, 19 **83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

|                                                                  |                                                                            |                                                                                                                                            |                                     |
|------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|
| 22b. SIGNATURE<br><b>Kathleen McShane</b>                        | DEGREE<br><b>MD</b>                                                        | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>10/11/83</b> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kathleen McShane</b> | 22e. ADDRESS<br><b>Landover Kaiser George Town Health Plan Landover Md</b> |                                                                                                                                            |                                     |

|                                                               |                              |                                                                  |                                                                                    |
|---------------------------------------------------------------|------------------------------|------------------------------------------------------------------|------------------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> | 23b. DATE<br><b>10-12-83</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cem.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Silver Spring, Montgomery, MD</b> |
|---------------------------------------------------------------|------------------------------|------------------------------------------------------------------|------------------------------------------------------------------------------------|

|                                                           |                                               |                                                     |                                                     |
|-----------------------------------------------------------|-----------------------------------------------|-----------------------------------------------------|-----------------------------------------------------|
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Beall Funeral Home</b> | 16000 Annapolis Road<br>Bowie, Maryland 20715 | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 13 1983</b> | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b> |
|-----------------------------------------------------------|-----------------------------------------------|-----------------------------------------------------|-----------------------------------------------------|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                            |                                                                                                                                        |                                                                                                                                                             |                                                                               |                                                                                                 |                                                                 |
|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Lillian D. (Mills) Wilmarth         |                                                                                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 19 1983                        |                                                                                                 | 2b. HOUR<br>9:45<br>P<br>M                                      |
| 3. SEX<br>Female                                                           | 4. RACE<br>White                                                                                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 17 1897                                                                                                         |                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86<br>YRS.                                                   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                           | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD                                           |                                                                 |
| 10. CITY OR TOWN OF DEATH<br>Rockville                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Collingswood Nursing Home |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>-                          |
| 13a. STATE<br>N.Y.                                                         |                                                                                                                                        | 13b. COUNTY<br>Suffolk                                                                                                                                      | 13c. CITY OR TOWN<br>Amityville                                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>155 Park Ave. 99999                      |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Washington Day            |                                                                                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Joanna - Reed                |                                                                                                 |                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |                                                                                                                                        | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-                                                                                                |                                                                               | 17. INFORMANT<br>19 Hutton St.<br>Gaithersburg, Md. 20877                                       |                                                                 |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4370

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Pneumonia

Cerebral arteriosclerosis

Generalized arteriosclerosis

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

5 days

3 years

5 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Urinary tract infection

|                                                                                                                                                                                                                                                                                                                               |                                                                        |                                                                                |                                                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                               |
| 22a. I certify that (a) (this hospital) attended the deceased from February 24 1983 to October 19 1983, that (b) (we) last saw the deceased alive on October 17 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (did) (did not) view the body after death. |                                                                        |                                                                                |                                                                                                                               |

|                                                                     |                       |                                                       |
|---------------------------------------------------------------------|-----------------------|-------------------------------------------------------|
| 22b. SIGNATURE<br>James R. Moore Jr. MD                             |                       | 22c. DATE SIGNED<br>10-20-83                          |
| 22d. PHYSICIAN'S ADDRESS (PRINT)<br>207 Brooks Ave Gaithersburg Md. |                       | 22e. ADDRESS<br>207 Brooks Ave Gaithersburg Md.       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation           | 23b. DATE<br>10/20/83 | 23c. NAME OF CEMETERY OR CREMATORY<br>Lee's Crematory |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Washington, D.C.      |                       | 23e. DATE REC'D. BY REGISTRAR<br>OCT 24 1983          |

|                                                                              |                                              |                                            |
|------------------------------------------------------------------------------|----------------------------------------------|--------------------------------------------|
| 24. FUNERAL DIRECTOR<br>NAME<br>Gahner Sandison F.H. Gaithersburg, Md. 20877 | 25a. DATE REC'D. BY REGISTRAR<br>OCT 24 1983 | 25b. REGISTRAR'S SIGNATURE<br>J. R. Gahner |
|------------------------------------------------------------------------------|----------------------------------------------|--------------------------------------------|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Stage 3  
System

Generalized arteriosclerosis  
Coronary arteriosclerosis  
Pneumonia

Chronic heart failure

1/2  
1/3  
1/4

Examination of the chest

10-20-22

K



James R. Moore

1000 1st St. N.E. Washington, D.C.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Andrew J. Wilson</b>                                                                                                                                                                                                                                                                                                    |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10/31/83</b>                                                                                                                                                                                                                                                                                               |  | 2b. HOUR<br><b>8:50 A.M.</b>                                                                                                                                |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>White</b>                                                                                                                                                                                                                                                                                                                              |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 31, 1917</b>                                                                                                 |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b>                                                                                                                                                                                                                                                                                                                   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>                                                                                                                                                                                                                                                                                          |  | 8. MARried <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, Md.</b>                                                                                                                                                                                                                                                                                          |  | 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b>                       |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Chief Financial Mgt. US Gov't.</b>                                                                                                                                                                                                                                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                    |  | 13a. STATE<br><b>D.C. 20015</b>                                                                                                                             |  |
| 13b. COUNTY<br><b>----</b>                                                                                                                                                                                                                                                                                                                                     |  | 13c. CITY OR TOWN<br><b>Washington, DC</b>                                                                                                                                                                                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  |
| 13e. STREET ADDRESS<br><b>5432 Connecticut Avenue, N.W.</b>                                                                                                                                                                                                                                                                                                    |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Daniel P. Wilson</b>                                                                                                                                                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary -- McGuigan</b>                                                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                             |  | 17. INFORMANT<br>ADDRESS<br><b>Ruth A. Wilson, 408 Roland St., SW, Vienna, Va.</b>                                                                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrhythmia</b><br><b>4254</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>cardiomyopathy</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <b>-----</b> |  |                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                             |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Congestive heart failure</b>                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                     |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                     |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                                                                                 |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                              |  | 22a. CERTIFY THAT (I) (this hospital) attended the deceased from <b>10/25</b> , to <b>10/31</b> , 19 <b>83</b> , that (II) (we) lost saw the deceased alive on <b>10/31</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><b>James H. Brodsky MD</b>                                                                                                                |  |
| 22c. DATE SIGNED<br><b>10/31/83</b>                                                                                                                                                                                                                                                                                                                            |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James H. Brodsky MD</b>                                                                                                                                                                                                                                                                                  |  | 22e. ADDRESS<br><b>4701 Willard Ave Chevy Chase, Md</b>                                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br><b>11/5/83</b>                                                                                                                                                                                                                                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cem.</b>                                                                                                |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Lackawanna, NY</b>                                                                                                                                                                                                                                                                                            |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Joseph Gawler's Sons, Inc.<br/>5130 Wisconsin Ave, NW, Washington, D.C. 20016</b>                                                                                                                                                                                                                         |  | 25. DATE REC'D BY REGISTRAR<br><b>NOV 9 1983</b>                                                                                                            |  |

1030 Macdonald Ave., St. Louis, Mo. 63104

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                              |  |                                                                                                                                       |                                                      |                                                                                                                                                             |                             |                                                                                      |                                                                                                 |                                                                 |                                            |  |
|--------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HOLLIS RAY WINKELHAKE |  |                                                                                                                                       | 2a. DATE OF DEATH MONTH DAY YEAR<br>OCTOBER 15, 1983 |                                                                                                                                                             |                             | 2b. HOUR<br>11:35 <sup>A</sup> M                                                     |                                                                                                 |                                                                 |                                            |  |
| 3 SEX<br>FEMALE                                              |  | 4. RACE<br>WHITE                                                                                                                      |                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>February 11, 1941                                                                                                     |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>42 YRS                                            |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Nebraska        |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                |                                                      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY COUNTY MD.                        |                                                                                                 |                                                                 |                                            |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE CLINICAL CENTER, NIH |                                                      |                                                                                                                                                             |                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laboratory Tech. |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Laboratory                 |                                            |  |
| 13a. STATE<br>NEBRASKA                                       |  |                                                                                                                                       | 13b. COUNTY<br>Unknown                               |                                                                                                                                                             | 13c. CITY OR TOWN<br>DUNBAR |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                 | 13e. STREET ADDRESS<br>P.O. Box 82 (83834) |  |

|                                                                            |  |                                                                 |                                                                      |                                                                            |  |
|----------------------------------------------------------------------------|--|-----------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------|--|
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Lawrence - Miller                |  |                                                                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Betty Jean Stouffer |                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>None |                                                                      | 17. INFORMANT<br>ADDRESS<br>Mr. DAVID ROY WINKELHAKE (HUSBAND) Same As #1. |  |

|                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                           |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4310 IMMEDIATE CAUSE (a) Recurrent pontine hemorrhage<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Pontine hemorrhage<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Days - weeks<br>14 months |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10

|                                                                                                                                                                                                                                                                                                                                |  |                                                                          |  |                                                                                            |  |                                                                                                                                       |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION<br>October 3, 1983                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Brainstem hemorrhage |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)             |  |                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                          |  |                                                                                                                                       |  |
| 22a. I certify that (he/she) this hospital) attended the deceased from SEPTEMBER 24, 1983, to OCTOBER 15, 1983, that (he/we) lost saw the deceased alive on OCTOBER 15, 1983, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (We) did (did not) view the body after death. |  |                                                                          |  |                                                                                            |  |                                                                                                                                       |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Ranjan Duara, M.D.                                                                                                                                                                                                                                                                    |  |                                                                          |  | 22c. ADDRESS<br>NATIONAL INSTITUTES OF HEALTH<br>CLINICAL CENTER, BETHESDA, MARYLAND 20205 |  | 22d. DATE SIGNED<br>10.16.83                                                                                                          |  |

|                                                                           |  |                        |  |                                                            |  |                                                                            |  |
|---------------------------------------------------------------------------|--|------------------------|--|------------------------------------------------------------|--|----------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation                 |  | 23b. DATE<br>Oct/17/83 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Crematory |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland, P.G. Co., Maryland |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Chambers Funeral Home Riverdale, Maryland |  |                        |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 19 1983               |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Smith                                |  |



THIRTY

20% COLIC





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                 |  |                                                                                                                                                  |                                                          |                                                                                                 |  |                                                                                                                            |  |                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|-------------------------|
| 1. FOR STATE #16 per F.H. 11/23/83<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                 |  |                                                                                                                                                  | REG. NO.                                                 |                                                                                                 |  |                                                                                                                            |  |                         |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Gerald Eugene Wise</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                 |  |                                                                                                                                                  | 2a. DATE OF DEATH MONTH DAY YEAR <b>October 12, 1983</b> |                                                                                                 |  |                                                                                                                            |  | 2b. HOUR <b>11:45AM</b> |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>Caucasian</b>                                                                                                                     |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Nov. 7, 1908</b>                                                                                           |                                                          | 6. AGE (IN YEARS LAST BIRTHDAY)<br>MONTHS DAYS HOURS MIN. <b>74 YRS.</b>                        |  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.                                                                                        |  |                         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>OHIO</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b>                            |  |                                                                                                                            |  |                         |
| 10. CITY OR TOWN OF DEATH<br><b>Olney, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  |                                                                                                                                                  |                                                          | 12a. USUAL OCCUPATION<br>(IF NOT WORKING LIFE)<br><b>Vocational Rehab. Spec.</b>                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Veterans Administrat</b>                                                           |  |                         |
| 13a. STATE<br><b>Florida</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br><b>Polk</b>                                                                                                                      |  | 13c. CITY OR TOWN<br><b>Indian Lake Estates</b>                                                                                                  |                                                          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>(33855) 9977<br/>166 DeSoto Ave. Box 3320</b>                                                    |  |                         |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ada Wise</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edna Mitchell</b>                                                                            |                                                          |                                                                                                 |  |                                                                                                                            |  |                         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                 |  | 16b. SOCIAL SECURITY NO.<br><b>220-38-2185</b>                                                                                                   |                                                          | 17. INFORMANT<br>ADDRESS<br><b>Frieda M. Wise, same as #13</b>                                  |  |                                                                                                                            |  |                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Pulmonary Failure</b><br><b>1570</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>metastatic carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>carcinoma Head of Pancreas</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                                 |  |                                                                                                                                                  |                                                          |                                                                                                 |  |                                                                                                                            |  |                         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                 |  |                                                                                                                                                  |                                                          |                                                                                                 |  |                                                                                                                            |  |                         |
| 19a. DATE OF OPERATION<br><b>9/15/83</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Obstructive Jaundice</b>                                                                 |  |                                                                                                                                                  |                                                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                         |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                   |                                                          |                                                                                                 |  |                                                                                                                            |  |                         |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                          |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                |                                                          |                                                                                                 |  |                                                                                                                            |  |                         |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/31, 1983</b> to <b>10-11-1983</b> , that (I) (we) lost<br>saw the deceased alive on <b>10-11-1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                                                                                       |  |                                                                                                                                                 |  |                                                                                                                                                  |                                                          |                                                                                                 |  |                                                                                                                            |  |                         |
| 22b. SIGNATURE<br><b>Oliver J. Lawless MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                 |  | DEGREE<br><b>MD.</b>                                                                                                                             |                                                          |                                                                                                 |  | 22c. DATE SIGNED<br><b>10-12-83</b>                                                                                        |  |                         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>OLIVER J. LAWLESS</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                 |  | 22e. ADDRESS<br><b>Rosmoor Medical Center S.S. MD 20946</b>                                                                                      |                                                          |                                                                                                 |  |                                                                                                                            |  |                         |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br><b>Oct 17, 1983</b>                                                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Quantico National</b>                                                                                   |                                                          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Triangle, Virginia</b>                         |  |                                                                                                                            |  |                         |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland 20850</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 19 1983</b>                                                                                              |                                                          | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                             |  |                                                                                                                            |  |                         |

BP

THE HONORABLE  
MEMBER OF PARLIAMENT  
FOR THE DISTRICT OF

STREET, NEW BRUNSWICK

NEW BRUNSWICK

NEW BRUNSWICK

NEW BRUNSWICK

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                   |                                                                                                                                                    |                                                                                                                                                             |                                                            |                                                                                                           |                                                                  |
|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Laura M. Wohlsen</b>                    |                                                                                                                                                    |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 - 12 - 83</b> |                                                                                                           | 2b. HOUR<br><b>613 AM</b>                                        |
| 3. SEX<br><b>Female</b>                                                           | 4. RACE<br><b>Caucasian</b>                                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 29, 1891</b>                                                                                               |                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b>                                                              | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                                      |                                                                  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Shady Grove Adventist Hospital</b> |                                                                                                                                                             |                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Singer</b>                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Music Entertainment</b>  |
| 13a. STATE<br><b>Maryland</b>                                                     |                                                                                                                                                    | 13b. COUNTY<br><b>Montgomery</b>                                                                                                                            | 13c. CITY OR TOWN<br><b>Rockville</b>                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>XX</b> |                                                                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Martin</b>                     |                                                                                                                                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Palmer</b>                                                                                    |                                                            |                                                                                                           |                                                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |                                                                                                                                                    | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N/A</b>                                                                                       |                                                            | 17. INFORMANT (Daughter) ADDRESS<br><b>4300 N. Ocean Blvd<br/>Mary Mountrey, Ft Lauderdale, FL 33308</b>  |                                                                  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**4140**  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b)

**ASAC**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

|                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                      |                                                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10 Oct 83</b> 19 to <b>12 Oct 83</b> 19, that (I) (we) last<br>saw the deceased alive on <b>11 October</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                      |  |                                                                                      |                                                                                                                               |
| 22b. SIGNATURE<br><b>Thomas E. Dooley, M.D.</b>                                                                                                                                                                                                                                                                                                             |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>Oct. 12, 1983</b>                                             |                                                                                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thomas E. Dooley M.D.</b>                                                                                                                                                                                                                                                                                       |  | 22e. ADDRESS<br><b>17904 Georgia Avenue, Olney, Maryland 20832</b>                                                                                   |  |                                                                                      |                                                                                                                               |

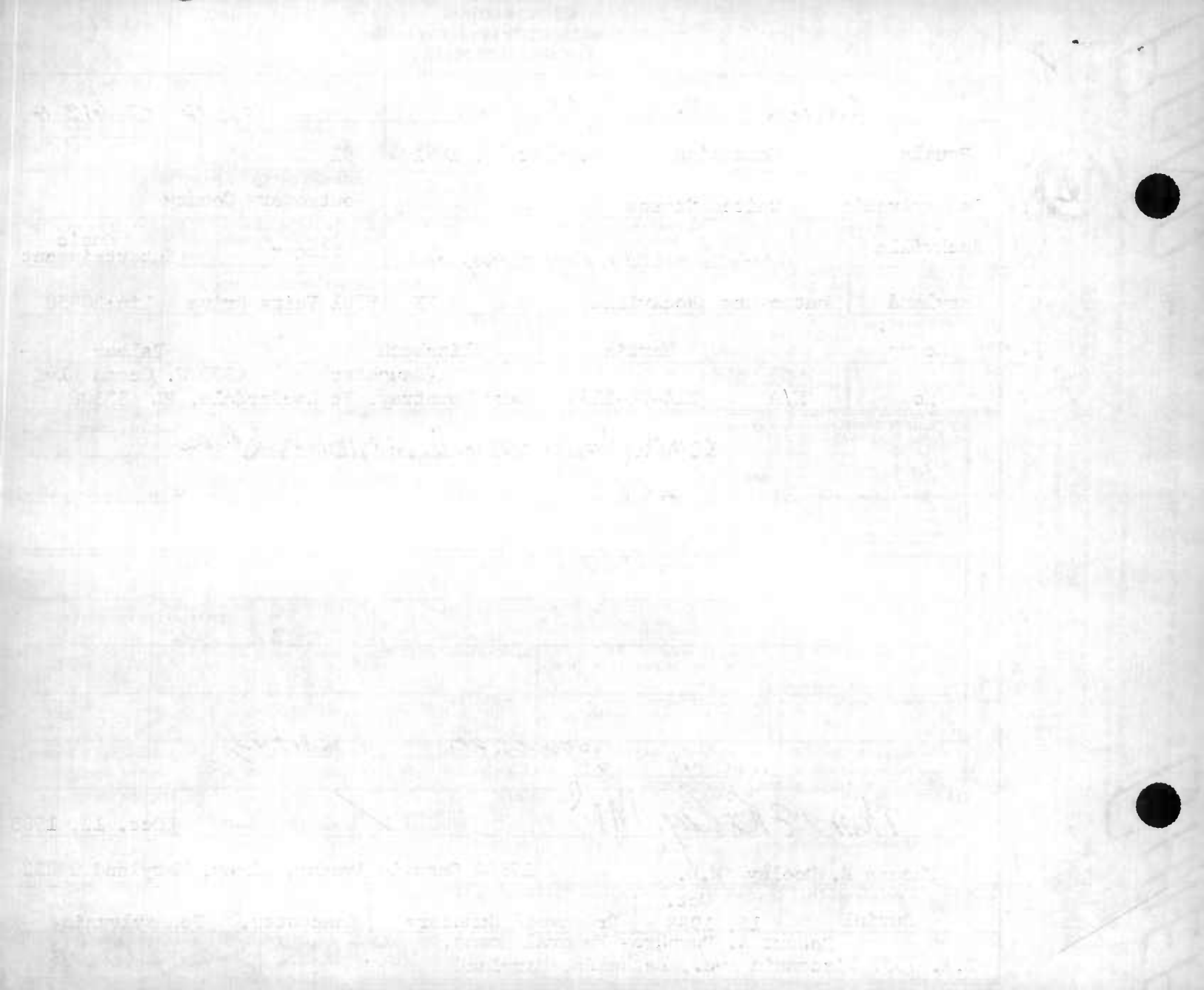
|                                                                                                                                   |                                   |                                                                 |                                                                              |
|-----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------------------------------------|------------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                     | 23b. DATE<br><b>Oct. 15, 1983</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenwood Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Lancaster, Pennsylvania</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Robert A. Pumphrey Funeral Homes,<br/>P.A. 7557 Wisconsin Ave., Bethesda, Maryland</b> |                                   | 25a. DATE REGD. BY REGISTRAR<br><b>OCT 19 1983</b>              |                                                                              |

25b. REGISTRAR'S SIGNATURE  
**John J. Canine**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5858.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                          |                                                              |                                                                                |                                                                     |                                                                |                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                              | MONTH                                                                          | DAY                                                                 | YEAR                                                           | 2b. HOUR                                                       |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        | FIRST                                                                                                                                                    | MIDDLE                                                       | LAST                                                                           |                                                                     |                                                                |                                                                |
| Mary C. Wolfe                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                          |                                                              | October 20, 1983                                                               |                                                                     | 7:25 PM                                                        |                                                                |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         |                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)                                                |                                                                     | 7. YRS.                                                        |                                                                |
| Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | White                                                                                                  | 1 20 1913                                                                                                                                                |                                                              | 70                                                                             |                                                                     |                                                                |                                                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                                                     | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH                                           |                                                                     |                                                                |                                                                |
| Washington DC                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | U.S.A.                                                                                                 |                                                                                                                                                          |                                                              | Montgomery MD.                                                                 |                                                                     |                                                                |                                                                |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                                                                |                                                                |
| OLNEY Md                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Montgomery General Hospital                                                                            |                                                                                                                                                          | Supervisor                                                   |                                                                                | F.B.I.                                                              |                                                                |                                                                |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        | 13b. STATE                                                                                                                                               | 13c. COUNTY                                                  | 13d. CITY OR TOWN                                                              | 13e. INSIDE CITY LIMITS?                                            | 13f. STREET ADDRESS                                            | 13g. ZIP CODE                                                  |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                        | MONTGOMERY                                                                                                                                               | SILVER SPRING                                                |                                                                                | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 3300 CHAPWICK COURT                                            | 20906                                                          |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                        | 15. MOTHER'S MAIDEN NAME                                                                                                                                 |                                                              |                                                                                |                                                                     |                                                                |                                                                |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                        | FIRST MIDDLE LAST                                                                                                                                        |                                                              |                                                                                |                                                                     |                                                                |                                                                |
| Maurice A. Wolfe                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                        | Nellie Spates                                                                                                                                            |                                                              |                                                                                |                                                                     |                                                                |                                                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                        | 16b. SOCIAL SECURITY NO.                                                                                                                                 |                                                              | 17. INFORMANT                                                                  |                                                                     | ADDRESS                                                        |                                                                |
| No                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                        | 549-88-7777                                                                                                                                              |                                                              | Sister Ann C. Wolfe                                                            |                                                                     | 419 Gallatin St. N.W. Washington, D.C. 20011                   |                                                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br><u>4479</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>POST OPERATIVE TO CONTROL ARTERIAL HEMORRHAGE 2 hours</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ANGIOPLASTY FOR SEVERE ARTERIAL DISEASE 7 hours</u> |                                                                                                        |                                                                                                                                                          |                                                              |                                                                                |                                                                     |                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1/2 hr.</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ADVANCED ATHEROSCLEROTIC OBLITERANTS</u>                                                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          |                                                              |                                                                                |                                                                     |                                                                |                                                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                              | 20a. AUTOPSY?                                                                  |                                                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                                                |
| 10.20.83                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                        | To control arterial hemorrhage                                                                                                                           |                                                              | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                                     | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTE BY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                           |                                                                                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                               |                                                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                                                     |                                                                |                                                                |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                   |                                                              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                     |                                                                |                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                          |                                                              |                                                                                |                                                                     |                                                                |                                                                |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10.17.83</u> to <u>10.20.83</u> , that (I) (we) lost the deceased on <u>10.20.83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                              |                                                                                |                                                                     |                                                                |                                                                |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                        | DEGREE                                                                                                                                                   |                                                              | 22c. DATE SIGNED                                                               |                                                                     |                                                                |                                                                |
| <u>Sol Shaz</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                        | M.D.                                                                                                                                                     |                                                              | 10.20.83                                                                       |                                                                     |                                                                |                                                                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                        | 22e. ADDRESS                                                                                                                                             |                                                              |                                                                                |                                                                     |                                                                |                                                                |
| Sol Shaz, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                        | 18111 PRINCE PHILIP Dr. Olney, Md. 20832                                                                                                                 |                                                              |                                                                                |                                                                     |                                                                |                                                                |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        | 23b. DATE                                                                                                                                                | 23c. NAME OF CEMETERY OR CREMATORY                           |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |                                                                |                                                                |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        | Oct. 24, 1983                                                                                                                                            | Mt. Olivet Cemetery                                          |                                                                                | Washington, D.C.                                                    |                                                                |                                                                |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |                                                              | 25b. REGISTRAR'S                                                               |                                                                     |                                                                |                                                                |
| Francis J. Collins                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                        | OCT 27 1983                                                                                                                                              |                                                              | <u>John J. Collins</u>                                                         |                                                                     |                                                                |                                                                |
| 500 University Blvd., W. Silver Spring, Md.                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                              |                                                                                |                                                                     |                                                                |                                                                |

1-7  
1-9  
1-33  
1-50  
1-1

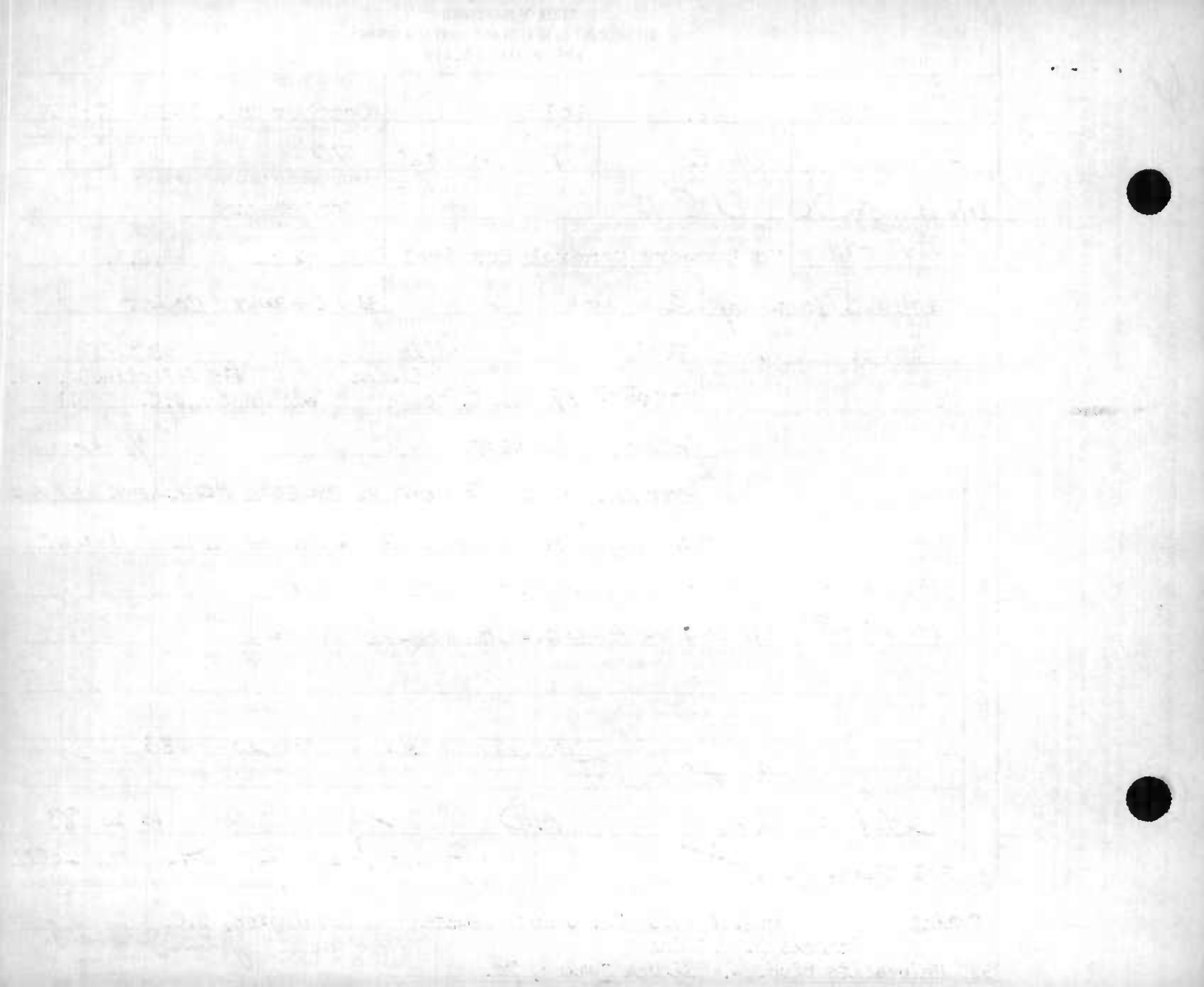
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death unless it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                     |                                     |                                                                                                                                                             |                                                                                                 | REG. NO.                                                                             |                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Marian Howard Woodfield                                                                                                                                                                                                                                                                                                                                                                           |                                     |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 26, 1983                                         |                                                                                      | 2b. HOUR<br>8:30 P M |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                                                                         | 4. RACE<br>WHITE                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAY 4, 1896                                                                                                           |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.                                           |                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                                                                                                                                                                                                                                                                                                                                                                                         | 7b. CITIZEN OF WHAT COUNTRY?<br>USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD                                |                      |
| 10. CITY OR TOWN OF DEATH<br>Olney                                                                                                                                                                                                                                                                                                                                                                                                       |                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Montgomery General Hospital                    |                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>H. Maker         |                      |
| 13a. COUNTY<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                       |                                     | 13b. CITY OR TOWN<br>Damascus                                                                                                                               | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS<br>26530 Ridge Road 20872                                        |                      |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HENRY HOWARD                                                                                                                                                                                                                                                                                                                                                                                   |                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>M. FLORENCE JONES                                                                                          |                                                                                                 |                                                                                      |                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                               |                                     | 16b. SOCIAL SECURITY NO.<br>212-24-4524                                                                                                                     |                                                                                                 | 17. INFORMANT<br>ADDRESS<br>Bradley M. Woodfield Same as #13                         |                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatosis</u><br>1749<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the breast.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ |                                     |                                                                                                                                                             |                                                                                                 |                                                                                      |                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><u>Terminal pneumonia</u>                                                                                                                                                                                                                                                                          |                                     |                                                                                                                                                             |                                                                                                 |                                                                                      |                      |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                      |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                               |                                     |                                                                                                                                                             |                                                                                                 |                                                                                      |                      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                 |                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                             |                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                      |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/26/83</u> to <u>10/26/83</u> , that (I) (we) lost saw the deceased alive on <u>10/26/83</u> , and that in (m) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)                                                                                                        |                                     |                                                                                                                                                             |                                                                                                 |                                                                                      |                      |
| 22b. SIGNATURE<br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                                     |                                     | DEGREE<br>MD                                                                                                                                                |                                                                                                 | 22c. DATE SIGNED<br>10/27/83                                                         |                      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOHN G. LODMELL MD                                                                                                                                                                                                                                                                                                                                                                              |                                     | 22e. ADDRESS<br>18111 PRINCE PHILIP DR. OLNEY MD                                                                                                            |                                                                                                 |                                                                                      |                      |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                   |                                     | 23b. DATE<br>OCT. 29, 1983                                                                                                                                  |                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br>Damascus Cemetery                              |                      |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Damascus Mont. Md.                                                                                                                                                                                                                                                                                                                                                                         |                                     |                                                                                                                                                             |                                                                                                 |                                                                                      |                      |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>FRANCIS H. BARBER LAYTONSVILLE, MD. 20879                                                                                                                                                                                                                                                                                                                                                        |                                     | 25a. DATE REC'D. BY REGISTRAR<br>OCT 28 1983                                                                                                                |                                                                                                 |                                                                                      |                      |
| 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                         |                                     |                                                                                                                                                             |                                                                                                 |                                                                                      |                      |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |                                                                         |                                                                                                                                                             |  |                                                                                            |  |                                                                                                                            |  |                                                                                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Mary Virginia Workman</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                  | 2a. DATE OF DEATH<br>MONTH <b>October</b> DAY <b>7</b> YEAR <b>1983</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>5:22</b> am                                                                 |  |                                                                                                                            |  |                                                                                                                                     |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>Caucasian</b>                                                                                                                      |                                                                         | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>1897</b>                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS                                           |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                                                                           |  | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN <b>0</b>                                                                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                             |                                                                         | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD                        |  |                                                                                                                            |  |                                                                                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Carriage Hill Nursing Center</b> |                                                                         |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                                                       |  |                                                                                                                                     |  |
| 13a. STATE<br><b>D.C.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                  |                                                                         | 13b. COUNTY<br><b>Washington</b>                                                                                                                            |  | 13c. CITY OR TOWN<br><b>D.C.</b>                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br><b>5221 42nd Street N.W.</b>                                                                                 |  |
| 14. FATHER'S NAME<br>FIRST <b>Elmer</b> MIDDLE <b>E.</b> LAST <b>Miller</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Nannie</b> MIDDLE <b>McDonald</b> LAST <b>McDonald</b>                                                                 |  |                                                                                            |  |                                                                                                                            |  |                                                                                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO<br><b>N/A</b>                                                                                                            |                                                                         | 17. INFORMANT (Husband)<br><b>William G. Workman, NW, Washington, D.C.</b>                                                                                  |  | ADDRESS <b>5221 42nd Street</b>                                                            |  |                                                                                                                            |  |                                                                                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Cerebral vascular disease</b><br><b>4442</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>arterial obstruction (femoral artery)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>3 weeks</b><br>Approximate interval between injury and death <b>3 weeks</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |                                                                                                                                                  |                                                                         |                                                                                                                                                             |  |                                                                                            |  |                                                                                                                            |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                 |                                                                         |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                                                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                                |                                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                            |  |                                                                                                                            |  |                                                                                                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                           |                                                                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                            |  |                                                                                                                            |  |                                                                                                                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>about mid 80</b> to <b>Sept 83</b> , that (I) (we) last saw the deceased alive on <b>Sept 28</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                 |  |                                                                                                                                                  |                                                                         |                                                                                                                                                             |  |                                                                                            |  |                                                                                                                            |  |                                                                                                                                     |  |
| 22b. SIGNATURE<br><b>D. R. Lawrenz</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |                                                                         | DEGREE<br>ATTENDING MEDICAL STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>     |  |                                                                                            |  | 22c. DATE SIGNED<br><b>October 7, 1983</b>                                                                                 |  |                                                                                                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>David R. Lawrenz</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                  |                                                                         | 22e. ADDRESS<br><b>1145 19th St., NW, Washington, D.C.</b>                                                                                                  |  |                                                                                            |  |                                                                                                                            |  |                                                                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE <b>October 11, 1983</b>                                                                                                                |                                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Quantico National</b>                                                                                              |  | 23d. LOCATION<br>CITY OR TOWN <b>Triangle</b> COUNTY <b>Virginia</b> STATE <b>Virginia</b> |  |                                                                                                                            |  |                                                                                                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Robert A. Pumphrey</b> ADDRESS <b>Homes, PA, Bethesda, Maryland 20814</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                  |                                                                         | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 11 1983</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conish</b>                                        |  |                                                                                                                            |  |                                                                                                                                     |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                         |  |                                                                                                                                          |                                                    |                                                                                                                                                             |                                                                              |                                                        |                                               |  |
|-----------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|--------------------------------------------------------|-----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>(Rev.) Malcolm Francis Wright                    |  |                                                                                                                                          | 2a. DATE OF DEATH MONTH DAY YEAR<br>October 17 '83 |                                                                                                                                                             |                                                                              | 2b. HOUR<br>M                                          |                                               |  |
| 3. SEX<br>Male                                                                          |  | 4. RACE<br>White                                                                                                                         |                                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 25 1914                                                                                                          |                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.             |                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                   |                                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD. |                                               |  |
| 10. CITY OR TOWN OF DEATH<br>Olney                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Montgomery General Hospital |                                                    |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Minister |                                                        | 12b. KIND OF BUSINESS OR INDUSTRY<br>Religion |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |                                                                                                                                          |                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                        |                                                                              |                                                        |                                               |  |
| 13a. STATE<br>Md.                                                                       |  | 13b. COUNTY<br>Montgomery                                                                                                                |                                                    | 13c. CITY OR TOWN<br>Gaithersburg                                                                                                                           |                                                                              | 13e. STREET ADDRESS<br>208 Russell Ave. 20877          |                                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William F. Wright                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lillian E. Rice                                                                         |                                                    |                                                                                                                                                             |                                                                              |                                                        |                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No              |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-05-8319A                                                                  |                                                    | 17. INFORMANT<br>ADDRESS<br>Alice Lee Wright 208 Russell Ave., Gaithersburg, Md. 20877                                                                      |                                                                              |                                                        |                                               |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

5964  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Chronic pyelonephritis

DUE TO, OR AS A CONSEQUENCE OF

(c) Hypotonic bladder dysfunction

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3 weeks

2 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Multiple sclerosis (duration 29 years)

|                                                                                                                                                                                                                                                                                                       |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 47 to 10-17-83, that (I) (we) last saw the deceased alive on 10-17-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>Jack Schumacher MD                                                                                                                                                                                                                                                                  |  |                                                                        |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>10-17-83                                                                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jack Schumacher, M.D.                                                                                                                                                                                                                                        |  |                                                                        |  | 22e. ADDRESS<br>105 Russell Ave., Gaithersburg, Md. 20877                                                                                            |  |                                                                                                                            |  |

|                                                                                                                        |  |                       |  |                                                           |  |                                                                       |  |
|------------------------------------------------------------------------------------------------------------------------|--|-----------------------|--|-----------------------------------------------------------|--|-----------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                 |  | 23b. DATE<br>10/19/83 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Forest Oak Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Gaithersburg Montg. Md. |  |
| 24. FUNERAL DIRECTOR'S NAME<br>Robert E. Sandison 316 E. Diamond Ave.<br>Gartner Sandison F.H. Gaithersburg, Md. 20877 |  |                       |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 19 1983              |  |                                                                       |  |
| 25b. REGISTRAR'S SIGNATURE<br>John J. Coker                                                                            |  |                       |  |                                                           |  |                                                                       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



CHIEFMAN

100% COTTON FIBER



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                |  |                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR<br><b>Mon Jack Yee</b>                                                                                                                                                                                                                                                                                                                       |  | REG. NO.                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mon Jack YEE</b>                                                                                                                                                                                                                                                                                                          |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 21 83</b>                                                                                               |  |                                                                                                                                                             |  | 7b. HOUR<br><b>5:30a. M</b>                                                                     |  |                                                                                                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br><b>Oriental</b>                                                                                                                           |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 24, 1905</b>                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Tai Shan, China</b>                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b>              |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired-Cook</b>         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Central Cafe</b>                                                                   |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY<br><b>Montgomery</b>                                                                                                                     |  | 13c. CITY OR TOWN<br><b>Silver Spring</b>                                                                                                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>11806-Dewey Road</b> <b>20904</b>                                                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Gee Chung Yee</b>                                                                                                                                                                                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Wong See</b>                                                                                     |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.<br><b>579-30-2328</b>                                                                                                       |  | 17. INFORMANT<br><b>Yuen Shing Yu (Son)</b>                                                                                                                 |  | ADDRESS<br><b>Same as #13</b>                                                                   |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b><br><b>5314</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>MYOCARDIAL INFARCTION</b><br>(c) <b>UPPER GASTROINTESTINAL HEMORRHAGE</b>       |  |                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>&lt;12h</b><br><b>5 days.</b><br><b>&lt;12h</b>                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>RENAL FAILURE RESPIRATORY FAILURE AORTIC ANEURYSM, VASCULAR INSUFFICIENCY</b>                                                                                                                                              |  |                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br><b>10/20/83</b>                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>BLEEDING GASTRIC ULCER</b>                                                                    |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/20</b> , 19 <b>83</b> to <b>10/21</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>10/20</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Ernest Hanowell</b>                                                                                                                                                                                                                                                                                                                            |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                                                                                                                                                             |  | 22c. DATE SIGNED<br><b>10/21/83</b>                                                             |  |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ERNEST HANOWELL</b>                                                                                                                                                                                                                                                                                                     |  | 22e. ADDRESS<br><b>10401 OLD GEORGETOWN, RD.</b>                                                                                                     |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br><b>Oct. 23, 1983</b>                                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Washington National Cemetery, Suitland, Pr. Geo., MD</b>                                                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                      |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br><b>J. Wm. Lee's Sons Co.</b>                                                                                                                                                                                                                                                                                                                |  | 24a. ADDRESS<br><b>300-4th St., NE, Wash., DC 20003</b>                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE                                                                      |  |                                                                                                                            |  |

BP

BIRTH

Oct. 23, 1923 Washington National Cemetery, District of Columbia

NO

27-30-2328 Yuen Shih Yu (son) Name as 13

Ge

Yuen

Yes

one

-

See

Barclay

Post Office Silver Spring

1180 - Dever Road

Silver Spring

Holy Cross Hospital

Retired - 6000

Central Cafe

2000 - China

United States

1000 - 1000

Life

Oriental

Oct. 24, 1923

77

1000 - 1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                         |  |                                                                                                                                                          |  | REG. NO.                                                                                                                   |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Irving Zapol</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                         |  | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>25</b> YEAR <b>83</b> 2b. HOUR <b>3:45</b> P.M.                                                              |  |                                                                                                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><b>WHITE</b>                                                                                                                 |  | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>12</b> YEAR <b>03</b>                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSPITAL</b> |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>REALTOR</b>                                         |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                         |  | 13b. COUNTY<br><b>MONTG.</b>                                                                                                                             |  | 13c. CITY OR TOWN<br><b>R'VILLE</b>                                                                                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>-----UNKNOWN-----</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>-----UNKNOWN-----</b>                                                                                |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>NONE</b>                                                                  |  | 17. INFORMANT<br>ADDRESS<br><b>MR. LAWRENCE ZAPOL 5515 HOOVER ST. BETHESDA, MD.</b>                                                                      |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory and Cardiac arrest</b><br><b>2762</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Renal Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metabolic acidosis</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 weeks</b><br><b>" "</b> |  |                                                                                                                                         |  |                                                                                                                                                          |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Coronary Heart Failure</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                         |  |                                                                                                                                                          |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                        |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                        |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/11</b> , 19 <b>83</b> , to <b>10/25</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>10/25</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                                              |  |                                                                                                                                         |  |                                                                                                                                                          |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Robert E. Rosenberg, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | DEGREE<br><b>MD</b>                                                                                                                     |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED<br><b>10/25/83</b>                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT E. ROSENBERG, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 22e. ADDRESS<br><b>1101 UNIVERSITY BLVD., SILVER SPRING, MD</b>                                                                         |  |                                                                                                                                                          |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><b>10-27-83</b>                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>JUDEAN MEM GDNS.</b>                                                                                            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>OLNEY MARYLAND</b>                                                        |  |
| 24. FUNERAL DIRECTOR<br><b>1170 ROCKVILLE PK. ROCKVILLE MD 20851</b><br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                         |  |                                                                                                                                                          |  |                                                                                                                            |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                   |                                                                                                                                                            |                                                                                                                                                             |                                                                                            |                                                                                                 |                                                         |
|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BERNARD ZARIN</b>                       |                                                                                                                                                            |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 26, 1983</b>                             |                                                                                                 | 2b. HOUR<br><b>4:00a<sub>M</sub></b>                    |
| 3. SEX<br><b>Male</b>                                                             | 4. RACE<br><b>White</b>                                                                                                                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 4, 1908</b>                                                                                                    |                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.                                               | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.               |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Wash., D.C.</b>                | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |                                                         |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Chevy Chase Nursing &amp; Convalescent</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ctr Owner (Ret)</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dry cleaner</b> |
| 13a. STATE<br><b>Maryland</b>                                                     |                                                                                                                                                            | 13b. COUNTY<br><b>Montgomery</b>                                                                                                                            | 13c. CITY OR TOWN<br><b>Sil.Spg.</b>                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                         |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Newman Zarin</b>                     |                                                                                                                                                            |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Yetta Levine</b>                       |                                                                                                 |                                                         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |                                                                                                                                                            | 16b. SOCIAL SECURITY NO.<br><b>079-16-2987A</b>                                                                                                             |                                                                                            | 17. INFORMANT<br>ADDRESS<br><b>Nathan Wolin; 1001 Spring St., SSpG, Md.</b>                     |                                                         |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIO PULMONARY ARREST**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**30 SECONDS**

1539  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) **METASTATIC ADENOCARCINOMA OF COLON****3 YEARS**

DUE TO, OR AS A CONSEQUENCE OF

(c) **CONGESTIVE HEART FAILURE: ASCVD****2 YEARS**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|                        |                                                  |                                                                                      |                                                                                                                               |
|------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                          |                                                            |                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------|

|                                                                                                              |                                                                        |                                                   |
|--------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------|
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE |
|--------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------|

22a. I certify that (I) (the informant) attended the deceased from 19 **71** to **10/26**, 19 **83**, that (I) (☒) lost  
saw the deceased alive on **10/2/83**, and that in (my) (☒) opinion death occurred on the date and hour and from the causes stated  
above. (I) (we) (did) (did not) view the body after death.

|                                           |                       |                                                                                                                                            |                                       |
|-------------------------------------------|-----------------------|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|
| 22b. SIGNATURE<br><i>Barrett L. Burka</i> | DEGREE<br><b>M.D.</b> | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>10-26-1983</b> |
|-------------------------------------------|-----------------------|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|

|                                                                        |                                                                  |
|------------------------------------------------------------------------|------------------------------------------------------------------|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BARRETT L. BURKA, M.D.</b> | 22e. ADDRESS<br><b>4607 Connecticut Avenue N.W., Wash., D.C.</b> |
|------------------------------------------------------------------------|------------------------------------------------------------------|

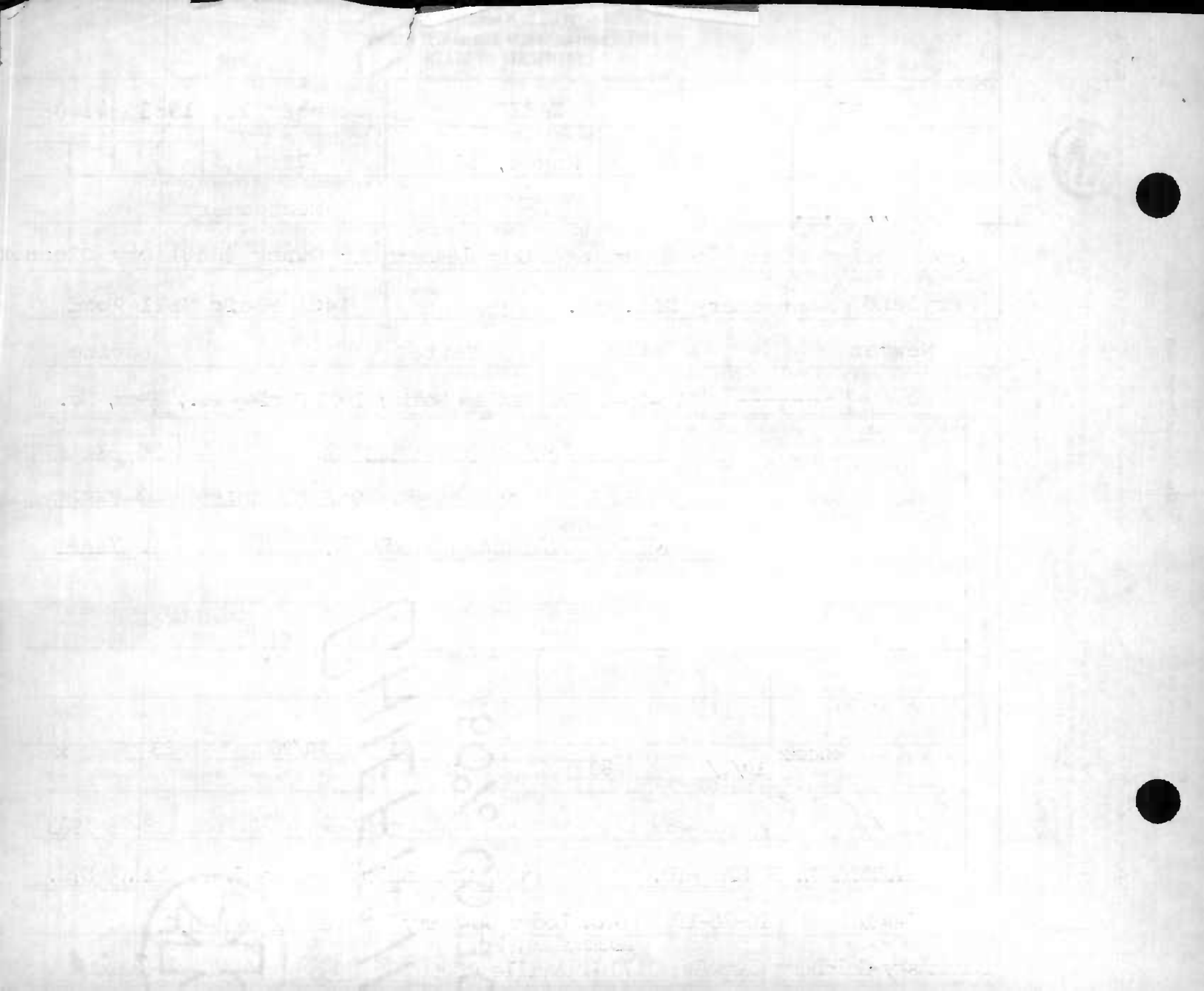
|                                                               |                                |                                                                  |                                                                       |
|---------------------------------------------------------------|--------------------------------|------------------------------------------------------------------|-----------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> | 23b. DATE<br><b>10-28-1983</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>D.C. Lodge Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, D.C.</b> |
|---------------------------------------------------------------|--------------------------------|------------------------------------------------------------------|-----------------------------------------------------------------------|

|                                                                                                |                                                     |                                                    |
|------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------|
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b> | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 31 1983</b> | 25b. REGISTRAR'S SIGNATURE<br><i>Sam J. Conner</i> |
|------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Parents may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                              |  |                                                                                                                                  |                                                 |                                                                                                                                                             |  |                                                                                      |  |
|--------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Walter Harry Zarske                                                   |  |                                                                                                                                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 12 83 |                                                                                                                                                             |  | 2b. HOUR<br>1:35 a.m.                                                                |  |
| 3. SEX<br>Male                                                                                               |  | 4. RACE<br>Caucasian                                                                                                             |                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>06 05 15                                                                                                              |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 Years                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.                                                                                             |                                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                        |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Maintenence                                                                             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Gov't                                           |  |
| 13a. STATE<br>Md.                                                                                            |  | 13b. COUNTY<br>Kent                                                                                                              |                                                 | 13c. CITY OR TOWN<br>Worton                                                                                                                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert Zarske                                                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marie Milkie                                                                    |                                                 | 13e. STREET ADDRESS<br>RFD - 1 Box 282 21678                                                                                                                |  |                                                                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes WWII |  | 16b. SOCIAL SECURITY NO.<br>183-03-3675                                                                                          |                                                 | 17. INFORMANT<br>Mrs. Jennie M. Zarske (Same as #13.)                                                                                                       |  |                                                                                      |  |

|                                                                                                                                                                                                                                                                                                                            |  |                                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>4140<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>ARTERIOSCLEROTIC HEART DISEASE</u><br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>IMMEDIATE</u> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                                                            |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>AUG 25</u> , 19 <u>83</u> to <u>OCT 12</u> , 19 <u>83</u> , that (we) lost saw the deceased alive on <u>OCT 10</u> , 19 <u>83</u> , and that in <u>our</u> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>Walter E. Goetz</u>                                                                                                                                                                                                                                                                                                                                |  |                                                                        |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>10/12/83                                                                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WALTER E. GOETZ MD                                                                                                                                                                                                                                                                                                             |  |                                                                        |  | 22e. ADDRESS<br>2309 SHOREFIELD RD WHITEHATON MD                                                                                                     |  |                                                                                                                            |  |

|                                                                   |  |                       |  |                                              |  |                                                    |  |
|-------------------------------------------------------------------|--|-----------------------|--|----------------------------------------------|--|----------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal              |  | 23b. DATE<br>10/13/83 |  | 23c. NAME OF CEMETERY OR CREMATORY           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE         |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Anatomy Board Balto., Md. |  |                       |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 18 1983 |  | 25b. REGISTRAR'S SIGNATURE<br><u>Sam J. Connel</u> |  |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

WHEAT